HOUSE BILL 728

42ND LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 1996

INTRODUCED BY

EDWARD C. SANDOVAL

AN ACT

RELATING TO HEALTH CARE; ENACTING THE PROVIDER SPONSORED HEALTH NETWORKS LAW.

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

Section 1. SHORT TITLE.--This act may be cited as the "Provider Sponsored Health Networks Law".

Section 2. PURPOSE OF ACT.--The purpose of the Provider Sponsored Health Networks Law is to facilitate the establishment of integrated health delivery systems, to encourage cooperative health care provider agreements, to promote community reinvestment of health expenditures in communities, to protect sole community and essential access community hospitals and other essential community health care providers, to establish state policy and a process of state immunization, to protect health care cooperative agreements from federal antitrust

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actions and to provide for the general registration and regulation of provider sponsored health networks by the department of insurance, the human services department and the department of health.

Section 3. DEFINITIONS.--As used in the Provider Sponsored Health Networks Law:

A. "basic health care services" means medical services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, diagnostic and therapeutic radiological services, mental health services or services for alcohol or drug abuse, dental, vision services and long-term rehabilitation treatment;

B. "capitated basis" means fixed per member per month payment or percentage of contractual payment wherein the provider assumes the full, partial or shared risk for the cost of contracted services without regard to the type, value or frequency of services provided;

C. "carrier" means a provider sponsored health network, an insurer, a nonprofit health care plan or other entity, including the state and federal government, responsible for the payment of benefits or provision of services under a group contract;

D. "certificate of public advantage" means a certificate issued by the department of health that specifies that the department of health, following rules and regulations

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developed by the department, has determined the advantages of a provider sponsored health network and that related cooperative agreements among providers outweigh possible reductions in competition and that the provider sponsored health network is beneficial and shall improve the health care delivery of the particular geographic area to be serviced;

E. "community reinvestment" means the portion of network revenues that are returned to the community served by the provider sponsored health network for programs promoting prevention and disease management and where no payment is received by the network for services provided;

F. "cooperative agreement" means an agreement between two or more providers for the sharing, allocation or referral of patients, personnel, instructional programs, support services and facilities, or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by providers;

G. "co-payment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid;

H. "deductible" means the amount an enrollee is responsible to pay out of pocket before the provider sponsored health network begins to pay the costs associated with treatment;

I. "enrollee" means an individual who is covered by

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a provider sponsored health network;

J. "evidence of coverage" means a contract or certificate showing the essential features and services of the provider sponsored health network coverage that is given to the subscriber by the provider sponsored health network or by the group contract holder;

K. "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;

L. "grievance" means a written complaint submitted in accordance with the provider sponsored health network's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the provider sponsored health network relative to the enrollee;

M. "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;

N. "group contract holder" means the person to whom a group contract has been issued;

O. "health care services" means any services included in the furnishing to any individual of medical, mental, dental or optometric care, 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

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services for the purpose of preventing, alleviating, curing or healing human physical or mental illness or injury;

P. "healthy communities plan" means a plan submitted annually by a registrant to the superintendent and the secretary of health that describes the provider sponsored health network's activities, services and costs as related to community reinvestment;

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

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

S. "managed payment basis" means agreements in which the financial risk is related primarily to the degree of utilization rather than to the cost of services;

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

U. "participating provider" means a provider as defined in Subsection W of this section who, under an express contract with the provider sponsored health network or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than co-payment or deductible, directly or indirectly from

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the provider sponsored health network;

V. "person" means an individual or any other legal entity;

W. "provider" means any physician, hospital or other person licensed or otherwise authorized to furnish health care services;

X. "provider sponsored health network" means any group of participating providers that undertake to directly provide or arrange for the delivery of basic health care services through cooperative agreements integrating different providers and contracts to enrollees on a prepaid basis, except for enrollee responsibility for co-payments or deductibles;

Y. "provider sponsored health network agent" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a contract for provider sponsored health network services or who takes or transmits payment for such a contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such;

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

AA. "subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the provider sponsored health network or, in the case of an individual contract, the person in whose name the contract is issued;

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BB. "superintendent" means the superintendent of insurance; and

CC. "uncovered expenditures" means the costs to the provider sponsored health network for health care services that are the obligation of the provider sponsored health network for which an enrollee, including the federal medicare-medicaid or successor program, may also be liable in the event of the provider sponsored health network's insolvency and for which no alternative arrangements have been made that are acceptable to the superintendent.

Section 4. ESTABLISHMENT OF PROVIDER SPONSORED HEALTH NETWORKS.--

A. Notwithstanding any law of this state to the contrary, any person may establish and operate a provider sponsored health network in compliance with the Provider Sponsored Health Networks Law. No person shall establish or operate a provider sponsored health network in this state without registering with the department of insurance and applying for a certificate of public advantage with the department of health.

B. Each registration and application for a certificate of public advantage shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the superintendent and the secretary of health and shall set forth or be accompanied by the following:

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(1) a copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

(2) a copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses and official positions and biographical information, on forms acceptable to the superintendent, of the persons who are to be responsible for the conduct of the affairs and day to day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee and the principal officers in the case of a corporation or the partners or members in the case of a partnership or association;

(4) a copy of any contract form made or to be made between any class of providers and the provider sponsored health network and a copy of any contract made or to be made between third party administrators, marketing consultants or persons listed in Paragraph (3) of this subsection and the provider sponsored health network;

(5) a copy of the form of evidence of coverage to be issued to the enrollees;

(6) a copy of the form of group contract, if

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any, to be issued to employers, unions, trustees or other organizations;

(7) financial statements showing the applicant's assets, liabilities and sources of financial support, including both a copy of the applicant's most recent regular certified financial statement and an unaudited current financial statement;

(8) a financial feasibility plan that includes detailed enrollment projections, the methodology for determining costs and charges during the first twelve months of operations, certified by an actuary or other person determined by the superintendent to be qualified, a three-year projection of balance sheets, a three-year projection of cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state and income and expense statements anticipated from the start of operations for three years or until the network has had net income for at least one year, if longer, a description of the proposed method of marketing and a statement of the sources of working capital as well as any other sources of funding;

(9) a power of attorney duly executed by the applicant, if not domiciled in this state, appointing the superintendent, his successors in office and duly authorized deputies as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action

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or proceeding against the provider sponsored health network on a cause of action arising in this state may be served;

(10) a statement or map reasonably describing the geographic area to be served;

(11) a description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) a description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) a description of the procedures to be implemented to meet the protection against insolvency requirements in the Provider Sponsored Health Networks Law;

(14) a list of the names, addresses and license numbers of all providers with which the provider sponsored health network has agreements;

(15) information determining the benefits and advantages of a provider sponsored health network to the health care delivery access, quality and efficiency for the particular geographic area to be served by the network to assist the department of health in issuing or renewing a certificate of

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public advantage to the network;

(16) an annual report as prescribed by the secretary of health specifying the benefits and advantages of the network regarding health care delivery access, quality and efficiency for the particular geographic area to be served by the network to facilitate the ongoing supervision and assessment of the network; and

(17) such other information as the superintendent or the secretaries of health or human services may require.

C. A provider sponsored health network shall, unless otherwise provided for in the Provider Sponsored Health Networks Law, file a notice describing any substantial modification of the operation set out in the information required by Subsection B of this section. The notice shall be filed with the superintendent prior to the modification. If the superintendent does not disapprove within thirty days of filing, the modification shall be deemed approved.

Section 5. PROVIDER SPONSORED HEALTH NETWORK REGISTRATION REQUIREMENTS AND PROCESS.--

A. Upon receipt of registration, the superintendent shall transmit copies of the registration and accompanying documents to the secretary of health and the secretary of human services if the provider sponsored health network intends to serve medicaid and medicare patients.

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B. The secretary of health shall certify to the superintendent whether the registrant, with respect to health care services to be furnished, has complied with the requirements of the Provider Sponsored Health Network Law.

C. The secretary of health shall certify to the superintendent, the registrant and, if necessary, the secretary of human services, within twenty days of receipt of the registration, that the proposed provider sponsored health network meets the requirements of the Provider Sponsored Health Networks Law or notify the provider sponsored health network that the network does not meet the requirements and specify in what respects it is deficient.

D. The superintendent shall within twenty days of receipt of certification or notice of deficiencies from the secretary of health pursuant to Subsection C of this section, or within thirty days of receipt of the registration indicated in Subsection A of this section if no request has been made of the secretary of health, notify the registrant of the deficiencies to any person filing a completed registration upon receiving the prescribed fees and upon the superintendent being satisfied that:

(1) the persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) any deficiencies identified by the

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secretary of health pursuant to Subsection C of this section have been corrected and the secretary of health has certified to the superintendent that the provider sponsored health network proposed plan of operation meets the requirements of the Provider Sponsored Health Networks Law;

(3) the provider sponsored health network will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through contract or otherwise, except to the extent of reasonable requirements for co-payments or deductibles, or both; and

(4) the provider sponsored health network is in compliance with financial and solvency provisions of the Provider Sponsored Health Networks Law.

Section 6. POWERS OF PROVIDER SPONSORED HEALTH NETWORKS.--

A. The powers of a provider sponsored health network include, but are not limited to, the following:

(1) the purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) transactions between or among affiliated entities, including loans and the transfer of responsibility under all contracts, including without limitation provider and

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subscriber contracts between or among affiliates or between the provider sponsored health network and its parent;

(3) the furnishing of health care services through providers, provider associations or agents for providers that are under contract with or employed by the provider sponsored health network;

(4) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) the contracting with an authorized insurer in this state for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the provider sponsored health network;

(6) the offering of other health care services, in addition to basic health care services; and

(7) the joint marketing of products with an insurer or other provider sponsored health networks authorized to do business in this state as long as the company that is offering each product is clearly identified.

B. A provider sponsored health network shall file notice, with adequate supporting information, with the superintendent prior to the exercise of any power granted in Paragraph (1), (2) or (4) of Subsection A of this section that may affect the financial soundness of the provider sponsored health network. The superintendent shall disapprove such

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exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the provider sponsored health network and endanger its ability to meet its obligations. If the superintendent does not disapprove within thirty days of the filing, it shall be deemed approved.

C. The superintendent may adopt rules and regulations exempting from the filing requirement of Subsection B of this section those activities having a de minimis effect.

Section 7. TAXATION.--Provider sponsored health networks shall be subject to the premium tax pursuant to Section 59A-6-2 NMSA 1978, except that the premium tax liability may be reduced by up to fifty percent based on an equivalent amount of community reinvestment expenditure by the provider sponsored health network as certified by the superintendent and based on provisions of services as specified in the healthy communities plan submitted by the network and approved by the superintendent.

Section 8. FIDUCIARY RESPONSIBILITIES--FIDELITY BOND.--

A. Any director, officer, employee or partner of a provider sponsored health network who receives, collects, disburses or invests funds in connection with the activities of the network shall be responsible for the funds in a fiduciary relationship to the network.

B. A provider sponsored health network shall maintain in force a fidelity bond or fidelity insurance on the

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employees, officers, directors and partners described in Subsection A of this section in an amount not less than two hundred fifty thousand dollars ($250,000) for each provider sponsored health network or a maximum of five million dollars ($5,000,000) in aggregate maintained on behalf of provider sponsored health networks owned by a common parent corporation or such sum as may be prescribed by the superintendent.

Section 9. QUALITY ASSURANCE PROGRAM.--

A. A provider sponsored health network shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. A provider sponsored health network shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(1) a written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

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(2) a written quality assurance plan that describes the following:

(a) the provider sponsored health network's scope and purpose in quality assurance;

(b) the organizational structure responsible for quality assurance activities;

(c) contractual arrangements, where appropriate, for delegation of quality assurance activities;

(d) confidentiality policies and procedures;

(e) a system of ongoing evaluation activities;

(f) a system of focused evaluation activities;

(g) a system for credentialing providers and performing peer review activities; and

(h) duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) a written statement describing the system of ongoing quality assurance activities, including:

(a) problem assessment, identification, selection and study;

(b) corrective action, monitoring, evaluation and reassessment; and

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(c) interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) a written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation and report format;

(5) written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided; and

(6) other polices and procedures as required by medicaid or medicare contracts.

C. A provider sponsored health network shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available for examination by the superintendent and by the secretary of health if requested by the superintendent, the secretary of health or the secretary of human services but shall not be disclosed to third parties except as permitted by the provisions the Provider Sponsored Health Networks Law.

D. A provider sponsored health network shall ensure

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the use and maintenance of an adequate patient record system that will facilitate documentation and retrieval of clinical information for the purpose of the provider sponsored health network evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Except as otherwise restricted or prohibited by state or federal law, enrollee clinical records shall be available to the superintendent or the secretary of health for examination and review to ascertain compliance with this section.

F. A provider sponsored health network shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, appropriate network staff and appropriate state officials.

Section 10. REQUIREMENTS FOR GROUP CONTRACT, INDIVIDUAL CONTRACT AND EVIDENCE OF COVERAGE.--

A. Every medicaid, medicare, group and individual contract holder is entitled to a group or individual contract. The contract shall not contain provisions or statements that are unjust, unfair, inequitable, misleading or deceptive or that encourage misrepresentation as described in Section 59A-16-4 NMSA 1978. The contract shall contain a clear statement of the following:

(1) name and address of the provider sponsored

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health network;

(2) eligibility requirements;

(3) benefits and services within the service area;

(4) emergency care benefits and services;

(5) out-of-area benefits and services, if any;

(6) co-payments, deductibles or other out-of-pocket expenses;

(7) limitations and exclusions;

(8) enrollee termination;

(9) enrollee reinstatement, if any;

(10) claims procedures;

(11) enrollee grievance procedures;

(12) continuation of coverage;

(13) conversion;

(14) extension of benefits, if any;

(15) coordination of benefits, if applicable;

(16) subrogation, if any;

(17) description of the service area;

(18) entire contract provision;

(19) term of coverage;

(20) cancellation of group or individual contract holder;

(21) renewal;

(22) reinstatement of group or individual

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contract holder, if any;

(23) grace period; and

(24) conformity with state law.

B. An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraphs (1) through (17) and (20) of Subsection A of this section.

C. In addition to those provisions required in Paragraphs (1) through (24) of Subsection A of this section, an individual contract shall provide for a ten-day period to examine and return the contract and have the payment refunded. If services were received during the ten-day period and the person returns the contract to receive a refund of the payment paid, the individual shall pay for the services.

D. Every subscriber shall receive an evidence of coverage from the group contract holder or the provider sponsored health network. The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading or deceptive or that encourage misrepresentation as described in Section 59A-16-4 NMSA 1978. The evidence of coverage shall contain a clear statement of the provisions required in Paragraphs (1) through (17) and (20) of Subsection A of this section.

E. The superintendent may adopt regulations establishing readability standards for individual contracts,

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group contracts and evidence of coverage forms.

F. No group or individual contract, evidence of coverage or amendment thereto shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the superintendent, subject to Subsections G and H of this section.

G. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the superintendent for approval.

H. Every form of group or individual contract, evidence of coverage or amendment thereto required to be filed pursuant to the provisions of Subsection F of this section shall be filed with the superintendent not less than thirty days prior to delivery or issue for delivery in this state. At the end of the review period, the form is deemed approved if the superintendent has taken no action. The filer shall notify the superintendent in writing prior to using a form that is deemed approved.

I. At any time, after thirty days' notice and for cause shown, the superintendent may withdraw approval of any form of group or individual contract, evidence of coverage or amendment thereto, effective at the end of the thirty-day notice

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period.

J. When a filing is disapproved or approval of a form of group or individual contract, evidence of coverage or amendment thereto is withdrawn, the superintendent shall give the provider sponsored health network written notice of the reasons for disapproval and in the notice shall inform the provider sponsored health network that within thirty days of receipt of the notice the provider sponsored health network may request a hearing. A hearing shall be conducted within thirty days after the superintendent has received the request for hearing.

K. The superintendent may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

Section 11. ANNUAL REPORT.--

A. Every provider sponsored health network shall annually, on or before the first day of March, file a report, verified by at least two principal officers, with the superintendent, the secretary of health and the secretary of human services if the network serves medicaid patients covering the preceding calendar year.

B. The report shall be on forms prescribed by the superintendent and shall include:

(1) a financial statement of the network

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prepared pursuant to forms prescribed by the superintendent, including its balance sheet and receipts and disbursements for the preceding year;

(2) any material changes in the information submitted pursuant to Subsection B of Section 4 of the Provider Sponsored Health Networks Law;

(3) the number of persons enrolled during the year and the number of enrollees as of the end of the year; and

(4) such other reasonable information materially relating to the performance of the provider sponsored health network as is necessary to enable the superintendent to carry out his duties.

C. In addition, the provider sponsored health network shall file by the dates indicated:

(1) audited financial statements as of the end of the preceding calendar year on or before June 1 or within one hundred twenty days following the end of its fiscal year, whichever is later;

(2) a list of the providers who have executed a contract that complies with Subsection E of Section 13 of the Provider Sponsored Health Networks Law on or before March 1; and

(3) a description of the grievance procedures and the total number of grievances handled through such procedures, a compilation of the causes underlying those grievances and a summary of the final disposition of those

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grievances, on or before March 1.

D. The superintendent may require such additional reports as are deemed necessary and appropriate to enable the superintendent to carry out his duties under the Provider Sponsored Health Networks Law.

Section 12. INFORMATION TO ENROLLEES OR SUBSCRIBERS.--

A. A provider sponsored health network shall provide to its subscribers or to its group contract holders for distribution to subscribers a list of providers upon enrollment and reenrollment.

B. Every provider sponsored health network shall notify its subscribers within thirty days of any material change in the operation of the organization that will affect the service to subscribers directly.

C. An enrollee shall be notified in writing by the provider sponsored health network of the termination of any designated primary care provider who provided health care services to that enrollee. The provider sponsored health network shall provide assistance to the enrollee in transferring to another participating primary care provider.

D. The provider sponsored health network shall provide to subscribers information on how services may be obtained, where additional information on access to services may be obtained and a number where the enrollee may contact the provider sponsored health network at no cost to the enrollee.

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Section 13. GRIEVANCE PROCEDURES.--

A. Every provider sponsored health network shall establish and maintain a grievance procedure that has been approved by the superintendent or the secretary of human services, if the network is serving medicaid patients, to provide procedures for the resolution of grievances initiated by enrollees. The provider sponsored health network shall maintain records regarding grievances received since the date of its last examination of such grievances.

B. The superintendent or the secretary of human services, if the provider sponsored health network is serving medicaid patients, may examine such grievance procedures and records.

Section 14. PROTECTION AGAINST INSOLVENCY.--

A. Provider sponsored health networks shall be subject to the following net worth requirements for conducting business or for providing non-medicaid or medicare program services:

(1) the provider sponsored health network shall have an initial net worth of one million five hundred thousand dollars ($1,500,000) and shall thereafter maintain the minimum net worth required under Paragraph (2) of this subsection;

(2) except as provided in Paragraphs (3) and (4) of this subsection, every provider sponsored health network shall maintain a minimum net worth equal to the greater of:

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(a) one million dollars ($1,000,000);

(b) two percent of annual contract revenues as reported on the most recent annual financial statement filed with the superintendent on the first one hundred fifty million dollars ($150,000,000) of contract revenues and one percent of annual contract revenue in excess of one hundred fifty million dollars ($150,000,000);

(c) an amount equal to the sum of three months, uncovered health care expenditures as reported on the most recent financial statement filed with the superintendent; or

(d) an amount equal to the sum of: 1) eight percent of annual health care expenditures for enrollees under prepaid contracts except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the superintendent; and 2) four percent of annual hospital expenditures for enrollees under prepaid contracts paid on a capitated basis and a managed hospital payment basis as reported on the most recent financial statement filed with the superintendent;

(3) a provider sponsored health network serving only medicaid or medicare patients under a medicaid managed care contract pursuant to Section 27-2-12.6 NMSA 1978 shall maintain a minimum net worth to be established by the human services department or:

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(a) twenty-five percent of the amount required by Paragraph (2) of this subsection by December 31, 1997;

(b) fifty percent of the amount required by Paragraph (2) of this subsection by December 31, 1998;

(c) seventy-five percent of the amount required by Paragraph (2) of this subsection by December 31, 1999; and

(d) one hundred percent of the amount required by Paragraph (2) of this subsection by December 31, 2000; and

(4) in determining net worth, other than the networth determined by the human services department, for the purposes of Paragraph (3) of this subsection:

(a) no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the superintendent and any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated;

(b) the interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses;

(c) any debt incurred by a surplus note meeting the requirements of Section 59A-34-23 NMSA 1978, and otherwise acceptable to the superintendent, shall not be

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considered a liability and shall be recorded as equity; and

(d) preferred stock shall not be considered debt.

B. Provider sponsored health networks shall be subject to the following deposit requirements:

(1) unless otherwise provided in Paragraph (2) of this subsection, each provider sponsored health network shall deposit with the superintendent or, at the discretion of the superintendent, with any network or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to him that at all times shall have a value of not less than three hundred thousand dollars ($300,000);

(2) a provider sponsored health network that is in operation on July 1, 1996 shall make a deposit equal to one hundred fifty thousand dollars ($150,000) and, in the second year, the amount of the additional deposit for a provider sponsored health network that is in operation on July 1, 1996 shall be equal to one hundred fifty thousand dollars ($150,000), for a total of three hundred thousand dollars ($300,000);

(3) the deposit shall be an admitted asset of the provider sponsored health network in the determination of net worth;

(4) all income from deposits shall be an asset of the network, but a provider sponsored health network that has

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made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other assets of equal amount and value;

(5) any securities deposited pursuant to the provisions of this subsection shall be approved by the superintendent before being deposited or substituted;

(6) the deposit shall be used to protect the interests of the provider sponsored health network's enrollees and to assure continuation of health care services to enrollees of a provider sponsored health network that is in rehabilitation or conservation;

(7) the superintendent may use a deposit made pursuant to the provisions of this subsection for administrative costs directly attributable to a receivership or liquidation, and if the provider sponsored health network is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the applicable liquidation law; and

(8) the superintendent may reduce or eliminate the deposit requirement if the provider sponsored health network deposits with the state treasurer, superintendent or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of such provider sponsored health network, cash, acceptable securities or surety and delivers to the superintendent a

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certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

C. Every provider sponsored health network shall include when determining liabilities an amount estimated in the aggregate to provide for:

(1) any unearned contract or capitated payment;

(2) the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, which are unpaid and for which the provider sponsored health network is or may be liable;

(3) the expense of adjustment or settlement of the claims described in Paragraph (2) of this subsection; and

(4) contract liabilities for continuation of coverage or conversion rights not covered by future premiums, contracts, capitated payments or hold harmless agreements.

D. Liabilities described in Subsection C of this section shall be computed in accordance with regulations adopted by the superintendent upon reasonable consideration of the ascertained experience and character of the provider sponsored health network.

E. Every contract between a provider sponsored health network and a participating provider of health care services shall be in writing and shall set forth that in the event the provider sponsored health network fails to pay for health care services as set forth in the contract, the

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subscriber or enrollee shall not be liable to the provider for any sums owed by the provider sponsored health network. In the event that the participating provider contract has not been reduced to writing or the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the provider sponsored health network. No participating provider or agent, trustee or assignee thereof may maintain any action at law against a subscriber or enrollee to collect sums owed by the provider sponsored health network.

F. The superintendent or the secretary of human services shall require that each provider sponsored health network have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering the plan, the superintendent or the secretary of human services may require:

(1) insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) provisions in provider contracts that obligate the provider to provide services for the duration of the period after the provider sponsored health network's insolvency for which premium payment has been made and until the

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enrollees' discharge from inpatient facilities;

(3) insolvency reserves;

(4) acceptable letters of credit; or

(5) any other arrangements to assure that benefits are continued as specified in Paragraphs (1) through (4) of this subsection.

G. An agreement to provide health care services between a provider and a provider sponsored health network shall require that if the provider terminates the agreement, the provider shall give the organization at least sixty days' advance notice of termination.

Section 15. UNCOVERED EXPENDITURES INSOLVENCY DEPOSIT.--

A. If at any time uncovered expenditures exceed ten percent of total health care expenditures, a provider sponsored health network shall place an uncovered expenditures insolvency deposit with the superintendent, the secretary of human services or with any organization or trustee acceptable to the superintendent through which a custodial or controlled account is maintained, cash or securities that are acceptable to the superintendent. Such deposit shall at all times have a fair market value in an amount of one hundred twenty percent of the provider sponsored health network's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of

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the month. If a provider sponsored health network is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this subsection.

B. The deposit required by Subsection A of this section is in addition to the deposit required by Section 13 of the Provider Sponsored Health Networks Law and is an admitted asset of the provider sponsored health network in the determination of net worth. All income from such deposits or trust accounts shall be assets of the provider sponsored health network and may be withdrawn from such deposit or account quarterly with the approval of the superintendent or the secretary of human services if the income from deposits or trust accounts relates to medicaid managed care contracts.

C. A provider sponsored health network that has made a deposit may withdraw that deposit or any part of the deposit if a substitute deposit of cash or securities of equal amount and value is made, the fair market value of the deposit exceeds the amount of the required deposit or the required deposit under Subsection A of this section is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the superintendent or the secretary of human services if the deposits, substitutions or withdrawals are made from medicaid managed care contracts.

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D. The deposit required under Subsection A of this section is in trust and may be used only as provided under this section. The superintendent or the secretary of human services in regard to medicaid managed care contracts may use the deposit of an insolvent provider sponsored health network for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the provider sponsored health network.

E. The superintendent or the secretary of human services in regard to medicaid managed care contracts may by regulation prescribe the time, manner and form for filing claims under Subsection D of this section.

F. The superintendent or the secretary of human services in regard to medicaid managed care contracts may by regulation or order require provider sponsored health networks to file annual, quarterly or more frequent reports as he deems necessary to demonstrate compliance with this section. The superintendent or the secretary of human services may require that the reports include liability for uncovered expenditures as well as an audit opinion.

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Section 16. ENROLLMENT PERIOD--REPLACEMENT COVERAGE IN THE EVENT OF INSOLVENCY.--

A. In the event of an insolvency of a provider sponsored health network, upon order of the superintendent or the secretary of human services in regard to medicaid managed care contracts, all other carriers that participated in the enrollment process with the insolvent provider sponsored health network at a group's last regular enrollment period shall offer such group's enrollees of the insolvent provider sponsored health network a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent provider sponsored health network the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

B. If no other carrier had been offered to some groups enrolled in the insolvent provider sponsored health network or if the superintendent or the secretary of human services in regard to medicaid managed care contracts determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent provider sponsored health network, the superintendent or the secretary of human services shall allocate equitably the insolvent provider sponsored health network's group contracts for such groups among all provider sponsored health networks

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that operate within a portion of the insolvent provider sponsored health network's service area, taking into consideration the health care delivery resources and total membership of each provider sponsored health network. Each provider sponsored health network to which groups are so allocated shall offer the groups the provider sponsored health network's existing coverage that is most similar to each group's coverage with the insolvent provider sponsored health network at rates determined in accordance with the successor provider sponsored health network's existing rating methodology.

C. The superintendent or the secretary of human services in regard to medicaid managed care contracts shall also allocate equitably the insolvent provider sponsored health network's nongroup enrollees that are unable to obtain other coverage among all provider sponsored health networks that operate within a portion of the insolvent provider sponsored health network service's area, taking into consideration the health care delivery resources of each such provider sponsored health network. Each provider sponsored health network to which nongroup enrollees are allocated shall offer such nongroup enrollees the provider sponsored health network's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent provider sponsored health network at rates determined in accordance with the successor provider sponsored health network's existing rating methodology.

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Successor provider sponsored health networks that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

D. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior provider sponsored health network contract or policy providing such hospital, medical or surgical expense or service benefits shall cover immediately all enrollees who were covered validly under the previous provider sponsored health network contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy. For purposes of this section, "discontinuance" means the termination of the contract between the group contract holder and a provider sponsored health network due to the insolvency of the provider sponsored health network and does not refer to the termination of any agreement between any individual enrollee and the provider sponsored health network.

E. Except to the extent benefits for the condition would have been reduced or excluded under the prior contractor or carrier's contract or policy, no provision in a succeeding

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contractor's or carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits existed before the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

Section 17. FILING REQUIREMENTS FOR RATING INFORMATION.--

A. No contract rate may be used until either a schedule of rates or methodology for determining rates has been filed with and approved by the superintendent or the secretary of human services in regard to medicaid managed care contracts. At the time the provider sponsored health network files the rate with the superintendent or the secretary of human services, it shall also file a schedule of benefits to which the rate applies.

B. Either a specific schedule of rates or a methodology for determining rates shall be established in accordance with actuarial principles for various categories of enrollees; provided that the payment applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. A certification by a qualified actuary or other qualified person acceptable to the superintendent or the secretary of human services in regard to medicaid managed care contracts as to the appropriateness of the rates or of the use

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of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

C. The superintendent or the secretary of human services in regard to medicaid managed care contracts may disapprove any such rates or methodology for determining rates found by him to be excessive, inadequate or unfairly discriminatory, considering the benefits to be provided. If the superintendent or secretary of human services disapproves the filing, he shall notify the provider sponsored health network, specifying the reasons for his disapproval. A hearing shall be conducted within thirty days after a request in writing by the person filing. The schedule or methodology shall be deemed approved if the superintendent or secretary of human services does not disapprove the filing within thirty days.

Section 18. REGULATION OF PROVIDER SPONSORED HEALTH NETWORKS AGENTS.--

A. Requirements and procedures for licensing of provider sponsored health networks agents shall be governed by the provisions of Chapter 59A, Articles 11 and 12 NMSA 1978 and any regulations adopted by the superintendent or the secretary of human services in regard to medicaid managed care contracts pertaining to those articles.

B. None of the following shall be required to hold a provider sponsored health network agent license:

(1) any regular salaried officer or employee of

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a provider sponsored health network who devotes substantially all of his time to activities other than the taking or transmitting of applications or membership fees or premiums for provider sponsored health network membership or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for provider sponsored health network membership;

(2) employers or their officers or employees or the trustees of any employee benefit plan to the extent that such employers, officers, employees or trustees are engaged in the administration or operation of any program of employee benefits involving the use of provider sponsored health network memberships, if those employers, officers, employees or trustees are not compensated directly or indirectly by the provider sponsored health network issuing the provider sponsored health network memberships;

(3) banks or their officers and employees to the extent that such banks, officers and employees collect and remit charges by charging same against accounts of depositors on the orders of such depositors; or

(4) any person or the employee of any person who has contracted to provide administrative, management or health care services to a provider sponsored health network and who is compensated for those services by the payment of an

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amount calculated as a percentage of the revenues, net income or profit of the provider sponsored health network, if that method of compensation is the sole basis for subjecting that person or the employee of the person to the provisions of the Provider Sponsored Health Networks Law.

C. The superintendent or the secretary of human services in regard to medicaid managed care contracts may by rule exempt certain classes of persons from the requirement of obtaining a license if:

(1) the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(2) other existing safeguards make regulation unnecessary.

Section 19. POWERS OF INSURERS.--

A. An authorized insurer may either directly or through a subsidiary or affiliate organize and operate a provider sponsored health network under the provisions of the Provider Sponsored Health Networks Law. Notwithstanding any other law that may be inconsistent with the cited law, any two or more such insurance companies or their subsidiaries or affiliates may jointly organize and operate a provider sponsored health network. The business of insurance is deemed to include the providing of health care by a provider sponsored health network owned or operated by an insurer or its subsidiary.

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B. An authorized insurer may contract with a provider sponsored health network to provide insurance or similar protection against the cost of care provided through provider sponsored health networks and to provide coverage in the event of the failure of the provider sponsored health network to meet its obligations. Among other things, under such contracts the insurer may make benefit payments to provider sponsored health networks for health care services rendered by providers.

Section 20. EXAMINATIONS.--

A. The superintendent or the secretary of human services in regard to medicaid managed care contracts may make an examination of the affairs of any provider sponsored health network and providers with whom the provider sponsored health network has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every three years.

B. The superintendent or the secretary of human services in regard to medicaid managed care contracts may make or request the secretary of health to make an examination concerning the quality assurance program of the provider sponsored health network and of any providers with whom the provider sponsored health network has contracts, agreements or other arrangements as often as is reasonably necessary for the

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protection of the interests of the people of this state.

C. Every provider sponsored health network and provider shall submit its books and records for examination and in every way facilitate the completion of the examination. Medical records of individuals and contract providers shall not be subject to examination. For the purpose of examinations, the superintendent, the secretary of health and the secretary of human services may administer oaths to and examine the officers and agents of the provider sponsored health network and the principals of the providers concerning their business.

D. The expenses of examinations under this section shall be assessed against the provider sponsored health network being examined and remitted to the superintendent and the secretary of human services in regard to medicaid managed care contracts.

E. In lieu of examination, the superintendent or the secretary of human services in regard to medicaid managed care contracts may accept the report of an examination made by the superintendent, secretary of health or secretary of human services of another state.

F. Examination procedures shall be governed by the applicable provisions of Chapter 59A, Article 4 NMSA 1978.

Section 21. CEASE AND DESIST ORDERS.--

A. The superintendent and the secretary of human services in regard to medicaid managed care contracts may issue

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cease and desist orders to any provider sponsored health network if:

(1) the provider sponsored health network is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 4 of the Provider Sponsored Health Networks Law, unless amendments to such submissions have been filed with and approved by the superintendent;

(2) the provider sponsored health network issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 9 and 16 of the Provider Sponsored Health Networks Law;

(3) the provider sponsored health network does not provide or arrange for basic health care services;

(4) the secretary of health has certified to the superintendent that the provider sponsored health network is unable to fulfill its obligations to furnish health care services;

(5) the provider sponsored health network is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) the provider sponsored health network has

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failed to correct, within the time prescribed by Subsection C of this section, any deficiency occurring due to the provider sponsored health network's prescribed minimum net worth being impaired;

(7) the provider sponsored health network has failed to implement the grievance procedures required by Section 12 of the Provider Sponsored Health Networks Law in a reasonable manner to resolve valid complaints;

(8) the provider sponsored health network or any person on its behalf has engaged in any practice that under Chapter 59A, Article 16 NMSA 1978 is defined or prohibited as or determined to be an unfair method of competition or an unfair or deceptive act or practice or fraudulent;

(9) the continued operation of the provider sponsored health network would be hazardous to its enrollees; or

(10) the provider sponsored health network has otherwise failed substantially to comply with the provisions of the Provider Sponsored Health Networks Law.

B. In addition to a cease and desist order pursuant to this section, the registrant or provider sponsored health network may be subjected to an administrative penalty of up to five thousand dollars ($5,000) for each cause for suspension or revocation, but if the violation is willful or intentional, the administrative penalty may be up to ten thousand dollars ($10,000).

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C. Whenever the superintendent or the secretary of human services in regard to medicaid managed care contracts finds that the net worth maintained by any provider sponsored health network subject to the provisions of the Provider Sponsored Health Networks Law is less than the minimum net worth required to be maintained pursuant to the provisions of Section 13 of the Provider Sponsored Health Networks Law, he shall give written notice to the provider sponsored health network of the amount of the deficiency and require the provider sponsored health network to:

(1) file with the superintendent or the secretary of human services a plan for correction of the deficiency acceptable to the superintendent or the secretary; and

(2) correct the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the superintendent or the secretary of human services.

D. A deficiency found to exist by the superintendent or the secretary of human services pursuant to the provisions of Subsection C of this section shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for issuance of a cease and desist order to the provider sponsored health network or for placing it in conservation, rehabilitation or liquidation.

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E. The provider sponsored health network or registrant may in writing request a hearing within thirty days from the date of mailing a cease and desist order or imposing an administrative penalty. If no written request is made, the order shall be final upon the expiration of the thirty days.

F. If the provider sponsored health network or registrant requests a hearing pursuant to the provisions of Subsection G of this section, the superintendent or secretary of human services shall issue a written notice of hearing and send it to the provider sponsored health network or registrant by certified or registered mail stating:

(1) a specific time for the hearing, which may not be less than twenty or more than thirty days after mailing of the notice of hearing; and

(2) a specific place for the hearing, which may be either in Santa Fe county or in the county where the provider sponsored health network's or registrant's principal place of business is located.

G. After a hearing held pursuant to the provisions of Subsection E of this section or upon failure of the provider sponsored health network to appear at the hearing, the superintendent or secretary of human services shall take whatever action he deems necessary based on written findings and shall mail his decision to the provider sponsored health network or registrant.

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H. The provisions of Chapter 59A, Article 4 NMSA 1978 shall apply to proceedings under this section to the extent they are not in conflict with Subsection F of this section.

I. When a cease and desist order has been invoked the provider sponsored health network shall proceed, immediately following the effective date of the order to cease and desist, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The superintendent or secretary of human services may, by written order, permit such further operation of the network as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section 22. SUMMARY ORDERS AND SUPERVISION.--

A. Whenever the superintendent or secretary of human services in regard to medicaid managed care contracts determines that the financial condition of any provider sponsored health network is such that its continued operation might be hazardous to its enrollees, creditors or the general public or that it has violated any provision of the Provider Sponsored Health Networks Law, he may, after notice and hearing, order the provider sponsored health network to take such action as may be reasonably necessary to rectify the condition or violation,

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including but not limited to one or more of the following:

(1) reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the superintendent;

(2) reduce the volume of new business being accepted;

(3) reduce expenses by specified methods;

(4) suspend or limit the writing of new business for a period of time;

(5) increase the provider sponsored health network's capital and surplus by contribution; or

(6) take such other steps as the superintendent or secretary of human services may deem appropriate under the circumstances, including suspension or revocation of the certificate of public advantage or assessment of administrative penalties as provided in Section 20 of the Provider Sponsored Health Networks Law.

B. For purposes of this section, the violation by a provider sponsored health network of any law of this state to which the provider sponsored health network is subject shall be deemed a violation of the provisions of the Provider Sponsored Health Networks Law.

C. The superintendent or secretary of human services in regard to medicaid managed care contracts is authorized to make rules and regulations setting uniform standards and

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criteria for early warning that the continued operation of any provider sponsored health network might be hazardous to its enrollees, creditors or the general public and setting standards for evaluating the financial condition of any provider sponsored health network, which standards shall be consistent with the purposes expressed in Subsection A of this section.

D. The remedies and measures available to the superintendent pursuant to provisions of this section shall be in addition to, and not in lieu of, the remedies and measures available to the superintendent under the provisions of Chapter 59A, Article 41 NMSA 1978.

Section 23. REGULATIONS.--The superintendent and the secretary of human services in regard to medicaid managed care contracts may, after notice and hearing, adopt and promulgate reasonable rules and regulations as are necessary or proper to carry out the provisions of the Provider Sponsored Health Networks Law.

Section 24. PENALTIES AND ENFORCEMENT.--

A. The superintendent or the secretary of health may, in lieu of suspension or revocation of a certificate of public advantage or an application for registration pursuant to the provisions of Section 20 of the Provider Sponsored Health Networks Law, levy an administrative penalty in an amount up to five thousand dollars ($5,000), except that if the violation is willful or intentional, the administrative penalty may be up to

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ten thousand dollars ($10,000). The superintendent may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

B. If the superintendent for any reason has cause to believe that any violation of the provisions of the Provider Sponsored Health Networks Law has occurred or is threatened, the superintendent may give notice to the provider sponsored health network and to the representatives or other persons who appear to be involved in the suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

C. A conference arranged under the provisions of Subsection B of this section shall not be governed by any formal procedural requirements and may be conducted in such manner as the superintendent or the secretary of human services in regard to medicaid managed care contracts deems appropriate under the circumstances.

D. The superintendent or secretary of human services in regard to medicaid managed care contracts may issue an order directing a provider sponsored health network or a

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representative of a provider sponsored health network to cease and desist from engaging in any act or practice in violation of the provisions of the Provider Sponsored Health Networks Law. Within thirty days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of that law have occurred. Such hearings shall be governed by the provisions of Chapter 59A, Article 4 NMSA 1978.

E. In the case of any violation of the provisions of the Provider Sponsored Health Networks Law, if the superintendent or secretary of human services in regard to medicaid managed care contracts elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order issued pursuant to Subsection D of this section, the superintendent or secretary may institute a proceeding to obtain injunctive or other appropriate relief in the Santa Fe county district court.

F. Notwithstanding any other provisions of the Provider Sponsored Health Networks Law, if a provider sponsored health network fails to comply with the net worth requirement of that law, the superintendent or the secretary of human services in regard to medicaid managed care contracts is authorized to take appropriate action to assure that the continued operation of the provider sponsored health network will not be hazardous to its enrollees.

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Section 25. FILINGS AND REPORTS AS PUBLIC DOCUMENTS.--All applications, filings and reports required by the Provider Sponsored Health Networks Law shall be treated as public documents, except those that are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 10 of that act.

Section 26. CONFIDENTIALITY OF MEDICAL INFORMATION AND LIMITATION OF LIABILITY.--

A. Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any provider by any provider sponsored health network shall be held in confidence and shall not be disclosed to any person except:

(1) to the extent that it may be necessary to carry out the purposes of the Provider Sponsored Health Networks Law;

(2) upon the express consent of the enrollee or applicant;

(3) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) in the event of claim or litigation between the person and the provider sponsored health network in which the data or information is pertinent.

B. A provider sponsored health network shall be

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entitled to claim any statutory privileges against disclosure of information described in Subsection A of this section that the provider who furnished the information to the provider sponsored health network is entitled to claim.

C. A person who in good faith and without malice takes any action or makes any decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any records, information or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the provider sponsored health network that established the committee or the officers, directors, employees or agents of the provider sponsored health network be liable for the activities of any such person. The provisions of this subsection do not relieve any person of liability arising from treatment of a patient.

D. The information considered by a health care review committee and the records of its actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee or officer, director or other member of a provider sponsored health network or its staff engaged in assisting the committee or any person assisting or furnishing information to the committee may be subpoenaed to

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testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities.

E. Information considered by a health care review committee and the records of its actions and proceedings that are used pursuant to Subsection D of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

F. To fulfill its obligations under Section 8 of the Provider Sponsored Health Networks Law, the provider sponsored health network shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

Section 27. AUTHORITY TO CONTRACT.--The secretary of health and the secretary of human services, in carrying out their obligations under the provisions of the Provider Sponsored Health Networks Law, may contract with qualified persons to make recommendations concerning the determinations required to be made by them, which recommendations may be accepted in full or in part or rejected entirely.

Section 28. CONTINUATION OF COVERAGE AND CONVERSION RIGHT.--

A. Every individual or group contract entered into

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by a provider sponsored health network and that is delivered, issued for delivery or renewed in this state on or after January 1, 1996 shall provide covered family members of subscribers the right to continue such coverage through a converted or separate contract upon the death of the subscriber or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the subscriber. Where a continuation of coverage or conversion is made in the name of the spouse of the subscriber, such coverage may, at the option of the spouse, include coverage to dependent children for whom the spouse has responsibility for care and support.

B. The right to a continuation of coverage or conversion pursuant to this section shall not exist with respect to any covered family member of a subscriber in the event the coverage terminates for nonpayment or nonrenewal of the contract or the expiration of the term for which the contract is issued. With respect to any covered family member who is eligible for medicaid or medicare or any other similar federal or state health program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance contract as defined by the rules and regulations adopted by the superintendent.

C. Coverage continued through the issuance of a converted or separate contract shall be provided at a reasonable, nondiscriminatory rate and shall consist of a form

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of coverage then being offered by the provider sponsored health network as a conversion contract. Continued and converted coverages shall contain renewal provisions that are not less favorable to the subscriber than those contained in the contract from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicaid or medicare supplement insurance contract, as defined by the rules and regulations adopted by the superintendent, after the attainment of the age or other standards of eligibility established for medicaid or medicare or any other similar federal or state health program.

D. At the time of inception of coverage, the provider sponsored health network shall provide each covered family member eighteen years of age or older a statement setting forth in summary form the continuation of coverage and conversion provisions of the subscriber's contract.

E. The eligible covered family member exercising the continuation or conversion right must notify the provider sponsored health network and make payment of the applicable cost within thirty days following the date such coverage otherwise terminates as specified in the contract from which continuation or conversion is being exercised.

F. Coverage shall be provided through continuation or conversion without additional evidence of insurability and

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shall not impose any preexisting condition, limitations or other contractual time limitations other than those remaining unexpired under the contract from which continuation or conversion is exercised.

G. Any probationary or waiting period set forth in the converted or separate contract is deemed to commence on the effective date of the applicant's coverage under the original contract.

Section 29. GOVERNING BODY.--The governing body of any provider sponsored health network shall include providers or other individuals, or both. Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions or through the use of other mechanisms.

Section 30. PROHIBITED PRACTICES.--

A. No provider sponsored health network or representative may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of the Provider Sponsored Health Networks Law:

(1) a statement or item of information is deemed to be untrue if it does not conform to fact in any

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respect which is or may be significant to an enrollee of, or person considering enrollment in, a provider sponsored health network;

(2) a statement or item of information is deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a provider sponsored health network, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist; and

(3) an evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care coverage and evidences of coverage therefor, to expect benefits, services, charges or other advantages which the evidence of coverage does not provide or which the provider sponsored health network issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

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B. An enrollee may not be canceled or nonrenewed on the basis of the status of his health.

C. No provider sponsored health network, unless also licensed as an insurer, may use in its name, contracts or literature any of the words "insurance", "casualty", "surety", "mutual" or any other words descriptive of the insurance, casualty or surety business if such words are used in a manner to imply that such coverages are being illegally offered by the provider sponsored health network or if deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

D. Any person not in possession of a valid registration and certificate of public advantage issued pursuant to the Provider Sponsored Health Networks Law shall not use the phrase "provider sponsored health network" or "PSHN" in the course of operation.

Section 31. PROVIDER DISCRIMINATION PROHIBITED.--No class of licensed individual providers willing to meet the terms and conditions offered by a provider sponsored health network shall be excluded from a provider sponsored health network. For purposes of this section, "providers" means those persons licensed under Chapter 61, Article 2, 4, 5, 6, 8, 9, 10 or 11 NMSA 1978.

Section 32. DOCTOR OF ORIENTAL MEDICINE--DISCRIMINATION PROHIBITED.--Doctors of oriental medicine as a class of licensed

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providers willing to meet the terms and conditions offered by a provider sponsored health network shall not be excluded from a provider sponsored health network.

Section 33. COVERAGE FOR ADOPTED CHILDREN.--

A. No individual or group provider sponsored health network contract shall be offered, issued or renewed in New Mexico on or after January 1, 1997 unless the contract covers adopted children of the subscriber or enrollee on the same basis as other eligible dependents.

B. The coverage required by this section is effective from the date of placement for the purpose of adoption and continues, unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

C. As used in this section, "placement" means in the physical custody of the adoptive parent.

Section 34. NEWLY BORN CHILDREN COVERAGE.--

A. All individual and group provider sponsored health network contracts delivered or issued for delivery in this state shall also provide that the health benefits applicable for children shall be payable with respect to a newly born child of the subscriber or the subscriber's spouse from the moment of birth.

B. All individual and group provider sponsored

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health network contracts delivered or issued for delivery in this state that do not provide health benefits applicable for children shall provide for an option to add to the coverage any newly born child of the insured, provided that the requirements of Subsection D of this section have been met.

C. The coverage for newly born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, where necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care facility for newly born infants.

D. If a specific payment is required to provide coverage for a child, the contract may require that a notification of birth of a newly born child and payment be furnished to the provider sponsored health network within thirty-one days after the date of birth in order to have the coverage from birth.

E. As used in this section and in Section 35 of the Provider Sponsored Health Networks Law, "tertiary care facility" means a hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

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Section 35. COVERAGE OF CHILDREN.--

A. A provider sponsored health network shall not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal tax return; or

(3) does not reside with the parent or in the network's service area.

B. When a child has health coverage through a provider sponsored health network of a noncustodial parent, the provider sponsored health network shall:

(1) provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state medicaid agency.

C. When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, the provider

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sponsored health network shall be required:

(1) to permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) not to disenroll or eliminate coverage of the child unless the network is provided satisfactory written evidence that:

(a) the court or administrative order is no longer in effect; or

(b) the child is or will be enrolled in comparable health coverage through another insurer or network that will take effect not later than the effective date of disenrollment.

D. A provider sponsored health network shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the medicaid program and covered for health benefits from the network that are different from requirements applicable to an agent or assignee of any other individual so covered.

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Section 36. MATERNITY TRANSPORT REQUIRED.--All individual and group provider sponsored health network contracts delivered or issued for delivery in this state which provide maternity coverage shall also provide, where necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility as defined in Section 33 of the Provider Sponsored Health Networks Law for newly born infants.

Section 37. HOME HEALTH CARE SERVICE OPTION REQUIRED.--

A. Each provider sponsored health network which delivers or issues for delivery in this state an individual or group contract shall make available to the contract holder the option of home health care coverage which includes benefits for the services described in this section.

B. Home health care coverage offered shall include:

(1) services provided by a registered nurse or a licensed practical nurse;

(2) health services provided by physical, occupational and respiratory therapists and speech pathologists; and

(3) health services provided by a home health aide.

C. Home health care coverage may be limited to:

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(1) services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days;

(2) services provided, directly or through contractual agreements, by a home health agency licensed in the state in which the home health services are delivered; and

(3) services, as set forth in Subsection B of this section, without which the insured would have to be hospitalized.

D. Coverage shall be provided for at least one hundred home visits per enrollee per year, with each home visit including up to four hours of home health care services.

E. For the purposes of this section, "home health care" means health services provided on a part-time, intermittent basis to an individual confined to his home due to physical illness.

Section 38. COVERAGE FOR MAMMOGRAMS.--

A. Each individual and group provider sponsored health network contract delivered or issued for delivery in this state shall provide coverage for low-dose screening mammograms for determining the presence of breast cancer. Such coverage shall make available one baseline mammogram to persons age thirty-five through thirty-nine, one mammogram biennially to persons age forty through forty-nine and one mammogram annually to persons age fifty and over. After January 1, 1997 coverage

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shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American college of radiology accreditation standards for mammography.

B. Coverage for mammograms may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same contract.

Section 39. COVERAGE FOR CYTOLOGIC SCREENING.--

A. Each individual and group provider sponsored health network contract delivered or issued for delivery in this state shall provide coverage for cytologic screening to determine the presence of precancerous or cancerous conditions and other health problems. The coverage shall make available cytologic screening, as determined by the health care provider in accordance with national medical standards, for women who are eighteen years of age or older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening.

B. Coverage for cytologic screening may be subject to deductibles and co-insurance consistent with those imposed on other benefits under the same contract.

C. For the purposes of this section:

(1) "cytologic screening" means a Papanicolaou test and pelvic exam for asymptomatic as well as symptomatic women; and

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(2) "health care provider" means any person licensed within the scope of his practice to perform cytologic screening, including physicians, physician assistants, certified nurse midwives and nurse practitioners.

State of New Mexico
House of Representatives

FORTY-SECOND LEGISLATURE

SECOND SESSION, 1996

February 2, 1996

Mr. Speaker:

Your RULES AND ORDER OF BUSINESS COMMITTEE, to whom has been referred

HOUSE BILL 728

has had it under consideration and finds same to be GERMANE in accordance with constitutional provisions.

Respectfully submitted,

_____

Barbara A. Perea Casey,

Chairperson

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Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 8 For 0 Against

Yes: 8

Excused: Nicely, Olguin, Pederson, Picraux, Rodella, J. G. Taylor, Wallach

Absent: None

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