

1 SENATE BILL 112

2 **54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019**

3 INTRODUCED BY

4 Elizabeth "Liz" Stefanics

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8 FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

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10 AN ACT

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

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

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

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

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

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

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

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

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

17 (4) remove a drug from the formulary;

18 (5) establish a prior authorization
19 requirement;

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

21 or

22 (7) impose a step-therapy restriction.

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

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

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

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

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

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

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

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

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

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

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

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

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1 reason.

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (3) increase the cost-sharing, copayment,
22 deductible or ~~[co-insurance]~~ coinsurance charges for a drug;

23 (4) remove a drug from the formulary;

24 (5) establish a prior authorization
25 requirement;

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

2 or

3 (7) impose a step-therapy restriction.

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

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

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

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

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

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

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

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

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

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1 formulary if the drug:

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

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

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

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

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

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

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

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

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

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

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1 SECTION 3. Section 59A-23-7.13 NMSA 1978 (being Laws
2 2013, Chapter 138, Section 3) is amended to read:

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

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

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

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

25 (3) increase the cost-sharing, copayment,

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1 deductible or [~~co-insurance~~] coinsurance charges for a drug;

2 (4) remove a drug from the formulary;

3 (5) establish a prior authorization

4 requirement;

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

6 or

7 (7) impose a step-therapy restriction.

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

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

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

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

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

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

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

25 (~~7) imposition of a step-therapy restriction~~

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1 ~~for a drug.~~

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

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

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

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

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

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

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

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

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

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

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

5 SECTION 4. Section 59A-46-50.4 NMSA 1978 (being Laws
6 2013, Chapter 138, Section 4) is amended to read:

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

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

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

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

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1 the formulary;

2 (3) increase the cost-sharing, copayment,
3 deductible or ~~[co-insurance]~~ coinsurance charges for a drug;

4 (4) remove a drug from the formulary;

5 (5) establish a prior authorization
6 requirement;

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

8 or

9 (7) impose a step-therapy restriction.

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

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

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

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

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

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

25 ~~(6) imposition or modification of a drug's~~

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1 ~~quantity limit; or~~

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

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

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

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

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

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

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

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

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

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

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

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

9 **SECTION 5.** Section 59A-47-45.4 NMSA 1978 (being Laws
10 2013, Chapter 138, Section 5) is amended to read:

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

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

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

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1 formulary;

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

6 (3) increase the cost-sharing, copayment,
7 deductible or [~~co-insurance~~] coinsurance charges for a drug;

8 (4) remove a drug from the formulary;

9 (5) establish a prior authorization requirement;

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

11 (7) impose a step-therapy restriction.

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

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

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

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

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

25 (5) ~~addition of a prior authorization~~

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1 requirement;

2 ~~(6) imposition or modification of a drug's~~
3 ~~quantity limit; or~~

4 ~~(7) imposition of a step-therapy restriction for~~
5 ~~a drug.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 supplies to be delivered during the plan year in which the new
2 provider contract is executed; provided that the provider
3 contract terminate by the end of the plan year in which it was
4 executed.

5 D. As used in this section:

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

11 (2) "provider" means:

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

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

17 SECTION 7. A new section of Chapter 59A, Article 22 NMSA
18 1978 is enacted to read:

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

21 A. An insurer that contracts with a provider for a
22 full plan year's services to be delivered to insureds under an
23 individual health insurance policy, health care plan or
24 certificate of health insurance that is delivered, issued for
25 delivery or renewed in this state shall execute that provider

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1 contract no sooner than ninety days from the beginning date of
2 the plan year in which the health care services or supplies are
3 to be delivered pursuant to that provider contract.

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

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

13 D. As used in this section:

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

19 (2) "provider" means:

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

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

25 SECTION 8. A new section of Chapter 59A, Article 23 NMSA

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1 1978 is enacted to read:

2 "[NEW MATERIAL] ANNUAL PROVIDER CONTRACTS--SHORTER
3 PROVIDER CONTRACTS.--

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

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

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

22 D. As used in this section:

23 (1) "new provider contract" means a contract
24 entered into with a provider with which an insurer did not
25 enter into a contract for health care services or supplies to

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1 be delivered during the current or preceding policy, plan or
2 certificate year; and

3 (2) "provider" means:

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

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

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

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

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

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

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

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

4 D. As used in this section:

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

10 (2) "provider" means:

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

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

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

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

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

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

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

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

17 D. As used in this section:

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

23 (2) "provider contract" means a contract for
24 health care services or supplies that a health care plan enters
25 into with a provider for health care services or supplies that

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

1 the health care plan will provide to subscribers pursuant to an
2 individual or group health care plan contract."

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