SENATE BILL 278

52ND LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2016

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; AMENDING AND ENACTING SECTIONS OF THE HEALTH MAINTENANCE ORGANIZATION LAW TO PROVIDE FOR NOTICE AND IMMEDIATE EXTERNAL APPEALS OF ADVERSE DETERMINATIONS OF MEDICAL NECESSITY RELATING TO PRESCRIPTION DRUGS AND INTRAVENOUS INFUSIONS.

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

SECTION 1. Section 59A-46-2 NMSA 1978 (being Laws 1993, Chapter 266, Section 2, as amended) is amended to read:

"59A-46-2. DEFINITIONS.--As used in the Health Maintenance Organization Law:

A. "adverse determination of medical necessity" means any of the following actions by a carrier or an agent of a carrier on the basis of a determination that a benefit that is otherwise provided is not medically necessary:

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(1) a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time; or

(2) a denial, reduction of, termination of or failure to provide or make payment for, in whole or in part, a benefit;

[~~A.~~] B. "basic health care services":

(1) means medically necessary services consisting of preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, diagnostic and therapeutic radiological services and services of pharmacists and pharmacist clinicians; but

(2) does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment;

[~~B.~~] C. "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided and includes the cost associated with operating staff model facilities;

[~~C.~~] D. "carrier" means a health maintenance organization, an insurer, a nonprofit health care plan or other entity responsible for the payment of benefits or provision of services under a group contract;

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[~~D.~~] E. "copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid;

[~~E.~~] F. "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider;

[~~F.~~] G. "deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment;

[~~G.~~] H. "enrollee" means an individual who is covered by a health maintenance organization;

[~~H.~~] I. "evidence of coverage" means a policy, contract or certificate showing the essential features and services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder;

[~~I.~~] J. "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;

[~~J.~~] K. "grievance" means a written complaint submitted in accordance with the health maintenance

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organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee;

[~~K.~~] L. "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;

[~~L.~~] M. "group contract holder" means the person to whom a group contract has been issued;

[~~M.~~] N. "health care services" means any services included in the furnishing to any individual of medical, mental, dental, pharmaceutical or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human physical or mental illness or injury;

[~~N.~~] O. "health maintenance organization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles;

[~~O.~~] P. "health maintenance organization agent" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health

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maintenance organization membership or who takes or transmits a membership fee or premium for such a policy or contract, other than for that person, or a person who advertises or otherwise makes any representation to the public as such;

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

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

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

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

[~~T.~~] U. "participating provider" means a provider as defined in Subsection [~~X~~] Y of this section who, under an express contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization;

[~~U.~~] V. "person" means an individual or other legal entity;

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[~~V.~~] W. "pharmacist" means a person licensed as a pharmacist pursuant to the Pharmacy Act;

[~~W.~~] X. "pharmacist clinician" means a pharmacist who exercises prescriptive authority pursuant to the Pharmacist Prescriptive Authority Act;

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

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

[~~Z.~~] AA. "subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued; and

[~~AA.~~] BB. "uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the superintendent."

SECTION 2. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PRESCRIPTION DRUG COVERAGE--ADVERSE

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DETERMINATION OF MEDICAL NECESSITY--IMMEDIATE EXTERNAL APPEAL--HEARING--ORDER.--

A. A carrier shall provide at least thirty days' written notice to an enrollee before implementing an adverse determination of medical necessity that relates to coverage for a prescription drug:

(1) if the enrollee has been prescribed the prescription drug for at least ninety days before the adverse determination process pursuant to this subsection has begun;

(2) that provides notice of the adverse determination, including grounds that include a finding that the prescription drug benefit that the enrollee is receiving is not medically necessary;

(3) that provides notice that the enrollee is entitled to:

(a) an immediate external appeal of the adverse determination of medical necessity pursuant to Subsection B of this section; and

(b) an internal appeal of adverse determination pursuant to state and federal law; and

(4) conforms to rules the superintendent has promulgated for the content and format of notice provided pursuant to this subsection.

B. An enrollee may make an immediate external appeal of an adverse determination of medical necessity

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relating to a prescription drug for which the enrollee has had a prescription for at least ninety days, pursuant to which:

(1) an enrollee may file a request, by written or oral means, for concurrent review and redetermination of the carrier's adverse determination of medical necessity immediately upon receipt of the carrier's notice of adverse determination of medical necessity;

(2) the superintendent or a hearing officer that the superintendent appoints shall review the adverse determination of medical necessity at a hearing conducted pursuant to Section 59A-4-15 NMSA 1978:

(a) within twenty days of the receipt of the enrollee's request for concurrent review;

(b) without imposing a requirement that the enrollee exhaust any internal appeals process before the superintendent or hearing officer reviews the matter; and

(c) after receiving the recommendation regarding a finding of medical necessity from a health care provider who: 1) has not previously reviewed the matter under review; and 2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure or treatment for which the prescription drug under review in the appeal was prescribed;

(3) the carrier shall not make the adverse determination of medical necessity effective until thirty days

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from the date the written notice was issued to the enrollee;

(4) at the close of the hearing, the superintendent shall review and consider the entire record and prepare findings of fact, conclusions of law and a recommended decision. The superintendent or hearing officer may submit a supplementary or dissenting opinion to the recommended decision;

(5) within five days after the hearing conducted pursuant to this subsection, the superintendent shall issue an order that either reverses or upholds the carrier's finding of medical necessity. The order shall be binding on the enrollee and the carrier. The order shall state that the enrollee and the carrier have the right to judicial review pursuant to Section 59A-4-20 NMSA 1978 and that state and federal law may provide other remedies; and

(6) neither the enrollee nor the health care insurer shall file a subsequent request for an immediate external appeal of an adverse determination of medical necessity of the same adverse determination that was the subject of the superintendent's order.

C. Nothing in this section shall abrogate the rights of an enrollee to internal or external review of an adverse determination or a grievance otherwise provided pursuant to state or federal law.

D. The superintendent shall promulgate rules

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relating to the provisions of this section by October 1, 2016."