TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 13 MANAGED HEALTH CARE - BENEFITS

13.10.13.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Division of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.
[13.10.13.1 NMAC - Rp, 13.10.13.1 NMAC, 09/01/2009]

13.10.13.2 SCOPE:

A. Applicability. This rule applies to health care insurers that are required to obtain a certificate of authority or licensure in this state and which provide, offer, or administer managed health care plans.

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) traditional fee-for-service indemnity plans;

(2) only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

(3) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit, including a stand-alone dental benefit plan, whether indemnity, PPO, or non-profit plan.

C. Conflicts. This rule relates to and should be read in conjunction with 13.10.16 NMAC, 13.10.17 NMAC, 13.10.21 NMAC, 13.10.22 NMAC, and 13.10.23 NMAC. If any provision in this rule conflicts with any provision of 13.10.17 NMAC, Grievance Procedures, or 13.10.16 NMAC, Provider Grievance, promulgated prior to the effective date of this rule, the provision in this rule shall apply.
[13.10.13.2 NMAC - Rp, 13.10.13.2 NMAC, 09/01/2009]

13.10.13.3 STATUTORY AUTHORITY: Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-18-21, 59A-19-5, 59A-19-6, 59A-22-19, 59A-22-20, 59A-22-21, 59A-22-42, 59A-22-43, 59A-22A-4, 59A-22A-5, 59A-22A-6, 59A-22A-7, 59A-23E-15, 59A-44-41, 59A-46-23, 59A-46-25, 59A-46-30, 59A-47-24, 59A-47-25, 59A-47-27, 59A-47-33, 59A-57-2, 59A-57-4, 59A-57-5, 59A-57-6, 59A-57-8, and 59A-57-11 NMSA 1978.
[13.10.13.3 NMAC - Rp, 13.10.13.3 NMAC, 09/01/2009]

13.10.13.4 DURATION: Permanent.
[13.10.13.4 NMAC - Rp, 13.10.13.4 NMAC, 09/01/2009]

13.10.13.5 EFFECTIVE DATE: September 1, 2009, unless a later date is cited at the end of a section.
[13.10.13.5 NMAC - Rp, 13.10.13.5 NMAC, 09/01/2009]

13.10.13.6 OBJECTIVE: The purpose of this rule is to ensure the availability, accessibility, and quality of health care services provided by health care insurers through managed health care plans. The rule provides uniform definitions; standards regarding patient rights and responsibilities; requirements regarding supplemental services and prescription drug coverage, when offered; and requirements for consumer assistance offices and consumer advisory boards within managed health care plans.
[13.10.13.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.13.7 DEFINITIONS. In addition to the following, this rule is subject to the definitions found in the Grievance Procedures Rule, 13.10.17 NMAC.

A. "Certified nurse-midwife" means any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico department of health as a certified nurse-midwife.

B. "Certified nurse practitioner" means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the board of nursing.

C. "Continuous quality improvement" means an ongoing and systematic effort to measure, evaluate, and improve a managed health care plan's process in order to continually improve the quality of health care services provided to its covered persons.

D. "Covered person" means an individual entitled to receive health care benefits provided by a health benefits plan, and includes individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

E. "Cytologic screening" means a papanicolaou test or liquid based cervical cytopathology, a human papillomavirus test and a pelvic exam for symptomatic as well as asymptomatic female patients.

F. "Division" means the New Mexico division of insurance.

G. "Emergency care" means health care procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

(1) jeopardy to the person's health;

(2) serious impairment of bodily functions;

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

(4) disfigurement to the person.

H. "Evidence of coverage" means a clear and conspicuous written statement of the essential features and medical services covered by the managed health care plan (MHCP), which may include a separate summary of benefits, as more particularly described at 13.10.23.8 NMAC, and which is provided to the covered person by the MHCP.

I. "FDA" means the United States food and drug administration.

J. "Grievance" means a complaint, and other documentation, as more particularly defined at 13.10.17.7 NMAC, submitted by or on behalf of a covered person.

K. "Health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

L. "Health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, prepaid dental plan, a multiple employer welfare arrangement or any other person providing a plan of health insurance or a managed health care plan subject to state insurance law and regulation.

M. "Health care professional" means a physician or other health care professional, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

N. "Health care services" means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

O. "Health maintenance organization (HMO)" means any person who undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for covered person responsibility for copayments or deductibles.

P. "Independent quality review organization (IQRO)" means an organization independent of the health care insurer or managed health care plan that performs external quality audits of managed health care plans and submits reports of its findings to both the managed health care plan and to the division.

Q. "Managed care" means a system or technique(s) generally used by third party payors or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

(1) prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;

(2) contracts with selected health care providers;

(3) financial incentives or disincentives for covered persons to use specific providers, services, prescription drugs, or service sites;

(4) controlled access to and coordination of services by a case manager; and

(5) payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

R. "Managed health care plan (MHCP or plan)" means a policy, contract, certificate or agreement offered or issued by a health care insurer, provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, except as otherwise provided in this subsection. A MHCP

either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer, provider service network, or plan administrator. Effective immediately, a MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies. For purposes of this section, "plan administrator" shall include and apply to an HMO or other health care insurer not required to be licensed under Section 59A-12A-2 NMSA 1978, but which is acting as a "plan administrator" as defined under the act." A MHCP includes a health benefits plan as defined under Subsection D of Section 59A-22A-3 NMSA 1978, as "the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available."

S. "Obstetrician-gynecologist" means a physician who is board eligible or board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

T. "Participating provider" means a provider who, under a contract (or through other arrangement) with the health care insurer offering a managed health care plan, or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the managed health care plan or health care insurer.

U. "Physician assistant" means a skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of physician assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed physician.

V. "Primary care practitioner (PCP)" means a health care professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care practitioners shall include but not be limited to general practitioners, family practice physicians, internists, pediatricians, and obstetricians-gynecologists, physician assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other health care professionals may also provide primary care.

W. "Prospective enrollee" means:

(1) in the case of an individual who is a member of a group, an individual eligible for enrollment in a MHCP through that individuals group; or

(2) in the case of an individual who is not a member of a group or whose group has not purchased or does not intend to buy a MHCP, an individual who has expressed an interest in purchasing individual plan coverage and is eligible for coverage by the plan.

X. "Provider" means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license.

Y. "Registered lay midwife" means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

Z. "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic persons and includes the x-ray examination of the breast using equipment that is specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening mammography includes two views for each breast. Screening mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

AA. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the managed health care plan, or in the case of an individual contract, the person in whose name the contract is issued.

BB. "Summary of benefits" means a summary of the benefits and exclusions, required to be given prior to or at the time of enrollment to a prospective subscriber by the health care insurer or group contract holder.

CC. "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.

DD. "Traditional fee-for-service indemnity benefit" means a fee-for-service indemnity benefit as defined at 13.10.17.7 NMAC, as a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered persons to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply

with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

EE. "Urgent care" means medically necessary health care services provided in emergencies or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

FF. "Utilization review" means a system for reviewing the appropriate and efficient allocation of medical services and hospital resources given or proposed to be given to a patient or group of patients.

[13.10.13.7 NMAC - Rp, 13.10.13.7 NMAC, 09/01/2009]

13.10.13.8 PATIENT RIGHTS AND RESPONSIBILITIES:

A. Each health care insurer through its managed health care plan (MHCP) shall implement written policies and procedures regarding the rights of covered persons and implementation of such rights.

B. At the time of enrollment, each health care insurer through its MHCP shall provide each subscriber, and upon request, a covered person, or a covered person's representative, in compliance with state or federal law, with a summary of benefits and exclusions, premium information and provider listing, along with information on how to access or obtain the evidence of coverage. Basic consumer information, including the phone number of the managed health care bureau, shall be included on a newly issued covered person's health insurance card, or on a separate wallet-sized card, to include the phone number and website of the managed health care bureau, issued simultaneously with the newly issued health insurance card.

C. The evidence of coverage shall include a complete statement that a covered person shall have the right, at a minimum:

(1) to available and accessible services when medically necessary, and in an HMO, as determined by the primary care or treating physician in consultation with the MHCP, 24 hours per day, seven days per week for urgent or emergency care services, and for other health care services as defined by the contract or the evidence of coverage;

(2) to be treated with courtesy and consideration, and with respect for the covered person's dignity and need for privacy;

(3) to be provided with information concerning the health care insurer's policies and procedures regarding products, services, providers, appeals procedures and other information about the MHCP and the benefits provided;

(4) in an HMO, to choose a primary care practitioner within the limits of the covered benefits, plan network, and as provided by this rule, including the right to refuse care of specific health care professionals;

(5) to receive from the covered person's physician(s) or provider, in terms that the covered person understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurers or MHCP's position on treatment options; if the covered person is not capable of understanding the information, the explanation shall be provided to his or her next of kin, guardian, agent or surrogate, if available, and documented in the covered person's medical record;

(6) to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the covered person understands;

(7) to prompt notification, as required in this rule, of termination or changes in benefits, services or provider network;

(8) to file a complaint or appeal with the health care insurer or the superintendent and to receive an answer to those complaints in accordance with existing law;

(9) to privacy of medical and financial records maintained by the health care insurer and its health care providers, in accordance with existing law;

(10) to know upon request of any financial arrangements or provisions between the health care insurer and its providers which may restrict referral or treatment options or limit the services offered to covered persons;

(11) to adequate access to qualified health professionals for the treatment of covered benefits near where the covered person lives or works within the service area of the MHCP;

(12) in an HMO, and to the extent available and applicable to the MHCP, to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating provider, and

an explanation of a covered person's financial responsibility when services are provided by a non-participating provider, or provided without required preauthorization;

(13) in a MHCP that provides benefits for out-of-network coverage, to an approved example of the financial responsibility incurred by a covered person when going out-of-network; inclusion of the entire "billing examples" provided by the superintendent available on the division's website at the time of the filing of the plan will be deemed satisfaction of this requirement; any substitution for, or changes to, the division's "billing examples" requires written approval by the superintendent;

(14) to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that a covered person must follow for prior authorization and utilization review;

(15) to a complete explanation of why care is denied, an opportunity to appeal the decision to the health care insurer's internal review, the right to a secondary appeal, and the right to request the superintendent's assistance.

D. The health care insurer shall establish and implement written policies and procedures regarding the responsibilities of covered persons. A complete statement of these responsibilities shall be included in the evidence of coverage.

[13.10.13.8 NMAC - Rp, 13.10.13.8 NMAC, 09/01/2009]

13.10.13.9 SUPPLEMENTAL HEALTH CARE SERVICES:

A. A health care insurer, through its MHCP, may provide to its covered persons supplemental health care services that are not basic health care services. For HMOs, basic health care services are defined and described at 13.10.21.8 NMAC. These supplemental health care services may be limited as to time and cost.

B. Additional fees: A health care insurer may determine the level and scope of any supplemental health care service provided to its covered persons in a MHCP, whether or not the service is listed in this section, and may charge additional fees for those services.

C. The following are not required as basic health care services, but may be provided as supplemental health care services:

(1) consultation with and referral to physicians and other health care professionals such as dentists, nurses, podiatrists, optometrists, chiropractic physicians, physician assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, certified nurse midwives and other professionals engaged in the delivery of health services who are licensed to practice, are certified, and are practicing under authority of the MHCP, a medical group, an independent practice association or other authority authorized by applicable New Mexico law when treatment exceeds that included in basic health care services;

(2) corrective appliances, prosthetics, and artificial aids, including hearing aids, except as required in Section 13-7-10 NMSA 1978;

(3) mental health services, including, but not limited to, outpatient evaluative, crisis intervention and short term therapeutic mental health services and inpatient psychiatric care, except as required in Section 59A-23E 18 NMSA 1978;

(4) cosmetic surgery;

(5) pharmaceuticals and other medicines prescribed on an outpatient basis by licensed physicians nurse practitioners, physician assistants or certified nurse-midwives to treat or prevent illness;

(6) ambulance services, other than for emergencies or otherwise deemed medically necessary;

(7) care for military service-connected disabilities for which a covered person is legally entitled to services and for which facilities are reasonably available to the covered person;

(8) care for conditions that state or local law requires be treated in a public facility;

(9) dental services not required as a basic health care service;

(10) vision care;

(11) personal or comfort items;

(12) long-term physical therapy and rehabilitation;

(13) durable medical equipment for home use, such as wheel chairs, surgical beds, respirators, and dialysis machines;

(14) diagnosis, medical treatment and referral services for the abuse of or addiction to alcohol or drugs, including inpatient substance abuse care in a facility licensed to provide residential alcohol and drug abuse services, except as required by Section 59A-23-6 NMSA 1978;

(15) home health care services which, if offered, at a minimum shall comply with Section 59A-22-36 and Section 59A-46-40 NMSA 1978;

(16) skilled or intermediate nursing care;

(17) custodial or domiciliary care;

(18) hearing care, except as required for children by Section 59A-22-34.5 NMSA 1978;

(19) experimental or investigational medical, surgical, other health care procedures or treatments, including drugs, unless approved as a basic health care service treatment or procedure by the health care insurer. As used in this section, "experimental" or "investigational" as related to drugs, devices, medical treatments or procedures means:

(a) the drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished;

(b) reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;

(c) reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or

(d) except as required by 13.10.13.10 NMAC, the drug or device is used for a purpose that is not approved by the FDA;

(e) for the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in Subsection A of 13.10.13.10 NMAC; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure;

(f) as used in this section, "experimental" or "investigational" does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

[13.10.13.9 NMAC - Rp, 13.10.13.10 NMAC, 09/01/2009]

13.10.13.10 PRESCRIPTION DRUGS:

A. No MHCP that provides coverage for prescription drugs as a basic or supplemental health care service or pursuant to inpatient, urgent, or emergency medical services shall limit or exclude coverage for any drug approved by the FDA on the basis that the drug has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided that:

(1) the drug has been recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider," or

(2) as provided for cancer clinical trials, pursuant to Section 59A-22-43 NMSA.

B. Coverage of a drug includes medically necessary services associated with the administration of the drug provided that such services would not be otherwise excluded from coverage.

C. Coverage of a drug includes coverage for prescription contraceptive drugs or devices, pursuant to Sections 59A-22-42 and 59A-46-44 NMSA 1978.

D. Nothing in this section requires:

(1) coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;

(2) coverage for experimental or investigational drugs not approved for any indication by the

(3) reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in a managed health care plan, contract, or policy, subject to the exceptions listed in Subsection D of 13.10.13.10 NMAC.

E. Every MHCP must allow covered persons to obtain drugs not on the formulary as though the drug were included in the formulary, based on the type of drug, how the drug is administered, and the medically necessary services, when the treatment for which the drug is prescribed is a covered benefit, and when the participating provider in consultation with the MHCP determines that:

(1) the formulary drug has been or is reasonably expected to be less effective for the covered person; or

(2) the formulary drug has caused or is reasonably expected to cause adverse reactions in the covered person.

[13.10.13.10 NMAC - Rp, 13.10.13.12 NMAC, 09/01/2009]

13.10.13.11 COORDINATION OF BENEFITS:

A. A health care insurer may or may not coordinate benefits in some or all of its group and individual managed health care plan contracts. However, a health care insurer which does coordinate benefits may do so only pursuant to the provisions in its plan contracts, all of which shall be fair, reasonable, and consistent with the objectives of this rule and shall comply with all applicable rules and regulations governing coordination of benefits.

B. A provision regarding coordination of benefits shall be presumed to be unfair and unreasonable if it:

(1) may relieve the health care insurer of a duty otherwise arising from a contract to deliver any health care service to any covered person in need of such service because the covered person may be or is entitled to coverage of the service by another health carrier; or

(2) results in any covered person who cooperates with such provision having greater personal liability for any particular health care service furnished by or through the health care insurer or received in reliance on the health care insurer than such person would have had in the absence of any other health carrier.

[13.10.13.11 NMAC - Rp, 13.10.13.24 NMAC, 09/01/2009]

13.10.13.12 COST SHARING:

A. All cost sharing (including copayments, deductibles, co-insurance, or similar charges) required of covered persons by the health care insurer or managed health care plan for the provision of health care services shall be reasonable and shall include any applicable state and federal taxes.

B. Any cost sharing requirement for the provision of testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency is presumptively unreasonable and is prohibited. For purpose of this rule, a public health emergency exists when declared by the ~~s~~state of New Mexico or federal government.

C. Cost sharing requirements, including any variations in contribution requirements based on the type of health care service rendered or provider used, shall be disclosed to covered persons in MHCP contracts, enrollment materials, and in the evidence of coverage.

D. No female covered person shall be assessed a higher cost sharing requirement, over and above the cost sharing required of all covered persons to be seen by a primary care physician, for choosing a women's health care provider as her primary care physician

E. Health care services for any disease or condition for which cost sharing is prohibited under Paragraph B of this section shall be subject to the Surprise Billing Protection Act, Sections 59A-57A-1 through 13, NMSA 1978 (the "Act"). Where there is no data available in the Act's benchmarking databases for a particular billing code, then the health care insurer or managed health care plan shall reimburse under the Act at one hundred fifty percent of the Medicare reimbursement rate applicable for the year in which the benchmarking data first becomes available.

[13.10.13.12 NMAC - Rp, 13.10.13.27 NMAC, 09/01/2009; A/E, 3/12/2020; A, 7/1/2020]

13.10.13.13 CONSUMER ASSISTANCE:

A. Consumer assistance office: Each MHCP shall establish and adequately staff a consumer assistance office. Those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval a plan of how the MHCP's consumer assistance office will be organized and established. At a minimum, the plan shall address:

(1) the staffing of the consumer assistance office, including whether the planned hours and level of staffing are sufficient for the numbers and types of covered persons served by the MHCP;

(2) the MHCP's arrangements to meet the needs of covered persons with special needs;

(3) how the consumer assistance staff will be trained;

(4) how the independence of staff assigned to assist consumers is assured; and

(5) whether staff will have the authority to assist consumers in filing and pursuing a grievance or appeal.

B. A MHCP new to this state shall submit a plan for establishing a consumer assistance office to the superintendent as part of its application for licensure.

C. The superintendent shall approve or reject a plan submitted by a MHCP within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

D. Consumer advisory board: Each MHCP shall establish and maintain a consumer advisory board.

(1) The consumer advisory board shall meet at least quarterly and shall advise the MHCP about the MHCP's general operations from the perspective of the enrollee as a consumer of health care.

(2) The consumer advisory board shall review the operations of and be advisory to the MHCP's consumer assistance office.

(3) All members of the consumer advisory board shall be current enrollees of the MHCP, employees of groups which subscribe to the MHCP, or be representatives of consumer organizations which represent the interests of health care consumers. No member of the consumer advisory board shall be an employee of the MHCP, nor shall the board members' immediate family be employees of the MHCP.

(4) The MHCP shall implement procedures whereby, when specific recommendations are made by the advisory board, representatives of the MHCP with responsibility for the substantive areas addressed in the recommendation will consider the matters raised in the recommendation and timely respond to the advisory board.

(5) The MHCP shall inform enrollees of the advisory board's existence and role in the operation of the MHCP in the evidence of coverage.

[13.10.13.13 NMAC - Rp, 13.10.13.30 NMAC, 09/01/2009]

13.10.13.14 PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18, 59A-46-25, 59A-57-11 NMSA 1978.

[13.10.13.14 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.13.15 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.13.15 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

HISTORY OF 13.10.13 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records-state records center and archives:

SCC-85-10, Insurance Department Regulation 46, Health Maintenance Organizations, filed 10/10/1985.

History of Repealed Material:

13.10.13 NMAC, Managed Health Care (filed 4/13/2007) repealed 09/01/2009.

Other History:

Those applicable portions of SCC-85-10, Insurance Department Regulation 46, Health Maintenance Organizations (filed10/10/1985) were replaced by 13 NMAC 10.13, Managed Health Care, effective 3/16/1997.

13 NMAC 10.13, Managed Health Care (filed 2/14/1997) was renumbered, reformatted, amended and replaced by 13.10.13 NMAC, Managed Health Care, effective 4/30/2007.

13.10.13 NMAC, Managed Health Care (filed 4/13/2007) was replaced by 13.10.13 NMAC, Managed Health Care - Benefits, effective 09/01/2009.