This rule was filed as 13 NMAC 10.7.

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 7 FINANCIAL REPORTING REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

13.10.7.1 ISSUING AGENCY: New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.
[6/1/98; Recompiled 11/30/01]

13.10.7.2 SCOPE: This rule applies to all health maintenance organizations (HMOs).
[6/1/98; Recompiled 11/30/01]

13.10.7.3 STATUTORY AUTHORITY: Sections 59A-46-9, 59A-46-12, 59A-46-22 and 59A-46-23 NMSA 1978.
[6/1/98; Recompiled 11/30/01]

13.10.7.4 DURATION: Permanent.
[6/1/98; Recompiled 11/30/01]

13.10.7.5 EFFECTIVE DATE: June 1, 1998, unless a later date is cited at the end of a section or paragraph.
[6/1/98; Recompiled 11/30/01]
[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.7.6 OBJECTIVE: The purpose of this rule is to ensure that HMO's meet minimum fiscal operational requirements sufficient to assume the risk of their covered subscribers and to establish requirements for the membership of HMO policy-making bodies.
[6/1/98; Recompiled 11/30/01]

13.10.7.7 DEFINITIONS: In addition to the definitions in 59A-46-2 NMSA 1978, the following terms have the meanings given here.

A. **"Health professional"** includes physicians, dentists, registered nurses, licensed practical nurses, podiatrists, optometrists, chiropractic physicians, physician assistants, certified nurse practitioners, certified nurse-midwives, registered lay midwives, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health care services who are licensed to practice in New Mexico, are certified, and are practicing under the authority of an HMO, medical group, hospital, individual practice association, or other entity authorized by applicable New Mexico law.

B. **"Individual practice association (IPA)"** means a partnership, association, corporation, or other legal entity which delivers or arranges for the delivery of health services and which has entered into written services arrangements with health professionals, a majority of whom are licensed to practice medicine or osteopathy.

C. **"Medical group"** means a partnership, association, corporation, or other group:

(1) that is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

(2) a majority of the members of which are licensed to practice medicine or osteopathy; and

(3) the members of which:

(a) after the end of the 48 month period beginning after the month in which the HMO for which the group provides health services becomes a qualified HMO, as their principal professional activity (over 50 percent individually) engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility (over 35 percent in the aggregate of their professional responsibility) for the delivery of health services to enrollees of an HMO;

(b) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services;

(c) share health (including medical) records and substantial portions of major equipment and of professional, technical, and administrative staff;

(d) establish an arrangement whereby an enrollee's enrollment status is not known to the health professional who provides health services to the enrollee.

D. **"Party-in-interest"** means:

(1) Any director, officer, partner, or employee responsible for management or administration of an HMO, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the HMO, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valued at more than 5 percent of the assets of the HMO, and, in the case of an HMO organized as a nonprofit corporation, a founder or member of the corporation under applicable state corporation law;

(2) Any entity in which a person described in 13 NMAC 10.7.7.4.1 [now Paragraph (1) of Subsection D of 13.10.7.7 NMAC]:

(a) is an officer or director;

(b) is a partner (if the entity is organized as a partnership);

(c) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(d) has a mortgage, deed of trust, note, or other interest valued at more than 5 percent of the assets of such entity;

(3) Any spouse, child, or parent of an individual described in 13 NMAC 10.7.7.4.1 [now Paragraph (1) of Subsection D of 13.10.7.7 NMAC].

E. **"Policy-making body of an HMO"** means a board of directors, board of trustees, executive committee, governing board, or other body of individuals which has the authority to establish policy for the HMO.

F. **"Significant business transaction"** means any business transaction or series of transactions during any one fiscal year of the HMO, the total value of which exceeds the lesser of $25,000 or 5 percent of the total operating expenses of the HMO.

[6/1/98; Recompiled 11/30/01]

13.10.7.8 INVESTMENTS: An HMO shall be treated as a life insurance company for purposes of applying the provisions of Chapter 59A, Article 9 NMSA 1978.

[6/1/98; Recompiled 11/30/01]

13.10.7.9 ANNUAL REPORTS: In addition to the requirements of Section 59A-46-9 NMSA 1978, each HMO shall provide to the superintendent on or before March 1 of each year, unless for good cause shown the superintendent authorizes an extension of time, the following:

A. a copy of the report, if any, filed with the U.S. department of health and human services' health care financing administration containing the information required to be reported by disclosing entities under regulations implementing Sections 1124 and 1902(a)(38) of the Social Security Act (see 42 CFR 420.206 and 42 CFR 455.104, respectively); and

B. a description of any of the following significant business transactions between the HMO and any party-in-interest that occurred during the previous fiscal year, and a justification that the costs of any such transaction do not exceed the costs which would have been incurred if the transaction had been undertaken with someone not a party-in-interest (or, if the costs are higher, a justification that such costs are consistent with prudent management and fiscal soundness):

(1) sale, exchange, or lease of property;

(2) furnishing, for consideration, goods, services (including management services), or facilities, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to enrollees by hospitals and other providers and by staff, medical groups, individual practice associations, or any combination of them; and

(3) lending money or otherwise extending credit.

[6/1/98; Recompiled 11/30/01]

13.10.7.10 ACCOUNTANTS:

A. **Independent accountant:** Whenever the superintendent orders, or this rule requires, that a financial statement or other report be audited or be accompanied by the opinion of a certified public accountant or public accountant, the accountant shall be independent of the HMO.

B. **Change of independent accountant:** When the HMO submits financial statements required by this rule and the certifying accountant is an accountant other than the accountant who certified the HMO's most recent filing, the HMO must provide the superintendent with a separate letter stating whether, in the twenty-four (24) months preceding the engagement of the new accountant, there was any disagreement with the former accountant on any matter involving accounting principles or practices, financial statement disclosures, or auditing procedures, which the former accountant would have referred to in his or her opinion or report to the superintendent if such issues were not resolved to his or her satisfaction. The letter must be verified by a principal officer of the HMO. The HMO shall also request the former accountant to provide it with a letter addressed to the superintendent stating whether the former accountant agrees with the statements contained in the HMO's letter and, if not, stating the reasons the former accountant disagrees with the statements in the letter. The two letters must be submitted to the superintendent within 45 days after the HMO engages the new accountant.

[6/1/98; Recompiled 11/30/01]

13.10.7.11 DUPLICATION OF FEDERAL REPORTING REQUIREMENTS: If the reporting requirements of this rule duplicate any federal reporting requirements, the HMO may request a waiver of the reporting requirements of this rule. In requesting such a waiver, the HMO must clearly state which federally required information will be duplicated by complying with which reporting requirement of this rule. The superintendent will grant such waivers only when the HMO's federally reported information is provided and is in a clear and easily discernible format.

[6/1/98; Recompiled 11/30/01]

13.10.7.12 FISCAL OPERATION: Each HMO shall have a fiscally sound operation as demonstrated by:

A. total assets being greater than total unsubordinated liabilities by an amount at least equal to the net worth requirements delineated in Section 59A-46-13 NMSA 1978;

B. sufficient cash flow and adequate liquidity to meet obligations as they become due;

C. if the HMO did not increase its net worth during the three most recent fiscal years, a financial plan satisfactory to the superintendent, which shall include:

(1) a detailed marketing plan;

(2) statements of revenues and expenses on an accrual basis;

(3) statements of sources and uses of funds; and

(4) balance sheets.

D. a plan for handling insolvency that meets the requirements in Section 59A-46-13F NMSA 1978 which contains at least one of the five kinds of assurances permitted by that paragraph;

E. insurance policies or other arrangements secured and maintained by the HMO and approved by the superintendent to insure the HMO against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks; and

F. the financial projections required by Section 59A-46-3C(8) NMSA 1978 which shall include projections until break-even, if such break-even is beyond the three-year period provided in that section.

[6/1/98; Recompiled 11/30/01]

13.10.7.13 ADMINISTRATIVE AND MANAGERIAL ARRANGEMENTS: Each HMO shall have administrative and managerial arrangements satisfactory to the superintendent as demonstrated by at least the following:

A. a policy-making body which exercises oversight and control over the HMO's policies and personnel to assure that management actions are in the best interests of the HMO and its enrollees; and

B. personnel and systems sufficient for the HMO to organize, plan, control and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of HMO. At a minimum, the HMO shall be managed by an executive whose appointment and removal are under the control of the HMO's policy-making body.

[6/1/98; Recompiled 11/30/01]

13.10.7.14 PROTECTION OF ENROLLEES: Each HMO shall adopt at least one of the following arrangements to protect its enrollees from incurring liability for payment of any fees which are the legal obligation of the HMO:

A. a contractual arrangement with any provider regularly used by the enrollees of the HMO prohibiting the provider from holding any enrollee liable for payment of any fees which are the legal obligation of the HMO;

B. a stand-by reinsurance agreement or membership in a guaranty association that is acceptable to the superintendent;

C. adequate financial reserves acceptable to the superintendent; or

D. other arrangements acceptable to the superintendent to protect enrollees.

[6/1/98; Recompiled 11/30/01]

13.10.7.15 FINANCIAL RISK: Each HMO shall assume full financial risk on a prospective basis for the provision of basic health services, except that it may:

A. obtain insurance or make other arrangements for the cost of providing to any enrollee basic health services the aggregate value of which exceeds $5,000 in any year;

B. obtain insurance or make other arrangements for the cost of basic health care services provided to enrollees other than through the HMO because medical necessity required provision of such services prior to the time the services could be secured through the HMO;

C. obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any fiscal year exceed 115 percent of its income for that fiscal year; or

D. make arrangements with physicians or other health professionals, health care institutions, or any combination of individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health care services by physicians or other health professionals or through the institutions.

[6/1/98; Recompiled 11/30/01]

13.10.7.16 TRANSACTIONS WITH PARTY-IN-INTEREST: With respect to any significant business transaction by the HMO with a party-in-interest:

A. The HMO shall disclose to its policy-making body all material facts concerning the transaction and the party-in-interest's interest in the transaction.

B. The policy-making body shall make such facts and the policy-making body's actions, if any, part of its minutes or, if no minutes are required of the policy-making body, shall otherwise make them a record of the HMO.

C. The HMO shall hand deliver or send by certified mail to the superintendent prior notice of the transaction. Such notice shall be given with reasonable time for the superintendent to object. The superintendent shall approve or disapprove such transaction within 30 days after receipt of the notice, and if no approval or disapproval has been granted within 30 days, the transaction shall be deemed approved by the superintendent.

[6/1/98; Recompiled 11/30/01]

13.10.7.17 POLICY-MAKING BODIES OF HMOS: No later than one year after becoming operational as a certified HMO, an HMO shall either:

A. assure that at least one-third of the membership of the HMO's policy-making body are enrollees of the HMO and that they reside in, or in proximity to, the service area of the HMO. No enrollee who is a party-in-interest shall be included in the minimum one-third member representation on the policy-making body. Persons serving on the policy-making body are not prohibited from receiving payments of directors' fees or other similar fees, or interest and dividends derived from enrollment in an HMO cooperative.

B. create an advisory board to the policy-making body. At least one-third of the members of the advisory board must be enrollees of the HMO who meet the criteria of 13 NMAC 10.7.17.1 [now Subsection A of 13.10.7.17 NMAC]. The advisory board shall meet at least annually and at least annually shall file a report of its recommendations with the policy-making body of the HMO. The report and any minority reports shall be forwarded to the superintendent annually.

[6/1/98; Recompiled 11/30/01]

13.10.7.18 FACILITATING PARTICIPATION BY FEDERAL OR STATE AGENCIES IN HMOs:
The superintendent may waive or modify any part of this rule in order to facilitate the purchase of HMO services by federal or state agencies in New Mexico.
[6/1/98; Recompiled 11/30/01]

HISTORY OF 13.10.7 NMAC:
Pre-NMAC History: This rule was originally filed with the State Records Center as:
SCC-85-10, Insurance Department Regulation 46 - Health Maintenance Organizations, on October 10, 1985; many parts of SCC-85-10 have been recompiled and substantially amended as part of 13 NMAC 10.13, Managed Health Care.

History of Repealed Material:
13 NMAC 10.7, Financial Reporting Requirements for Health Maintenance Organizations, was repealed effective 5-31-98 and re-promulgated as 13 NMAC 10.7, Financial Reporting Requirements for Health Maintenance Organizations, effective 6/1/98.