TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 23 MANAGED HEALTH CARE PLAN CONTRACTING

13.10.23.1 ISSUING AGENCY: Public Regulation Commission, Insurance Division.
[13.10.23.1 NMAC - N, 09/01/2009]

13.10.23.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer managed health care plans subject to the Insurance Code of the state of New Mexico:

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

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

(2) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit.

C. Conflicts. This rule relates to and should be read in conjunction with 13.10.13, 13.10.16, 13.10.17, 13.10.21 and 13.10.23 NMAC. If any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care-Benefits, 13.10.16 NMAC, Provider Grievances, or 13.10.17. NMAC Grievance Procedures Rule, the provisions in this rule shall apply.
[13.10.23.2 NMAC - N, 09/01/2009]

13.10.23.3 STATUTORY AUTHORITY: Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-59A-15-16, 59A-16-4, 59A-16-5, 59A-16-11, 59A-16-12, 59A-16-12.1, 59A-16-13, 59A-16-15, 59A-16-16, 59A-16-17, 59A-18-16, 59A-19-4, 59A-19-5, 59A-19-6, 59A-23E-15, 59A-44-34, 59A-44-41, 59A-46-7, 59A-46-8, 59A-46-23, 59A-46-25, 59A-46-27, 59A-46-30, 59A-46-32, 59A-46-34, 59A-47-33, 59A-47-34, 59A-57-2, 59A-57-4, 59A-57-6, and 59A-57-11, NMSA 1978.
[13.10.23.3 NMAC - N, 09/01/2009]

13.10.23.4 DURATION: Permanent.
[13.10.23.4 NMAC - N, 09/01/2009]

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

13.10.23.6 OBJECTIVE: The purpose of this rule is to clarify contracting between both the health care insurer and enrollees and health care providers under managed health care plans.
[13.10.23.6 NMAC - N, 09/01/2009]

13.10.23.7 DEFINITIONS:

A. In addition to the following, this rule is subject to the definitions found in Managed Health Care - Benefits, 13.10.13 NMAC.

B. "Medical record" means all information maintained by a health care provider relating to the past, present or future physical or mental health of a patient, and for other provision of health care to a patient. This information includes, but is not limited to, the health care provider's notes, reports and summaries, and x-rays and laboratory and other diagnostic test results. A patient's complete medical record includes information generated and maintained by the health care provider, as well as information provided to the health care provider by the patient, by any another health care provider who has consulted with or treated the patient, and other information acquired by the health care provider about the patient in connection with the provision of health care to the patient. A medical record does not include medical billing, insurance forms or correspondence and communication related thereto.
[13.10.23.7 NMAC - N, 09/01/2009]

13.10.23.8 INFORMATION PROVIDED TO COVERED PERSONS AND READABILITY OF MANAGED HEALTH CARE PLAN CONTRACTS:

A. Evidence of coverage: At the time of enrollment, each managed health care plan (MHCP) shall provide each covered person with information on how to access and obtain an evidence of coverage. Upon request at any time after enrollment, the covered person shall be provided with the evidence of coverage. Each evidence of

coverage offered to covered persons, and prospective covered persons shall state in clear, accurate, and conspicuous language, in not less than 10 point font, written such that it can be easily understood by the average covered person, and so that it comports with the requirements of the "Policy Language Simplification Law," Chapter 59A, Article 19 NMSA 1978, the following information:

(1) the name of the health care insurer and managed health care plan and its principal place of business, including its address and telephone number;

(2) definitions for words that have meanings other than common general usage;

(3) for an HMO, a description of the HMO's service area;

(4) a complete list or description of the comprehensive basic health care services, urgent health care services, emergency health care services, and, if applicable, supplemental health care services available within the MHCP's service or geographical area, and any other benefits to which the covered person is entitled under the particular plan;

(5) an explanation of how participation in the managed health care plan may affect the potential covered person's choice of physician, hospital, or other health care provider;

(6) eligibility requirements for coverage, including a statement of conditions on eligibility for benefits;

(7) conditions of cancellation, which shall include a statement that if a covered person believes coverage was canceled due to health status or health care requirements, race, gender, age, or sexual orientation, he may appeal termination to the superintendent;

(8) the name, address, and toll-free telephone number of the superintendent;

(9) a statement that a copy of the evidence of coverage will be provided upon request if the covered person is unable to obtain a copy of the contract from the covered person's employer or other contract holder;

(10) conditions for renewal and reinstatement;

(11) any procedures for filing claims;

(12) in bold typeface, or through an equally or more effective means, highlight any and all exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including deductibles or copayments, or co-insurance; when presented on the plan's website or through other internet means, this information may be highlighted with movement, color, pop-up material, and other devices;

(13) any other requirements or procedures necessary for covered persons to obtain particular health care services, such as additional copayments, prior authorizations, second opinions, and consultations with or referrals to specialists, physicians, or other providers other than the primary care physician;

(14) the covered person's personal financial obligation for non-covered health care services;

(15) a clear and complete summary of where, and in what manner, information is available regarding how a covered person obtains services, including emergency and out-of-area services;

(16) a toll-free telephone number and a web-based or other electronic methods through which the covered person may contact the MHCP for additional information on obtaining health care services or for other inquiries regarding the plan, including benefit information and plan requirements;

(17) for all contracts, a list of relevant copayments and all other out of pocket expenses paid by the covered person;

(18) for individual and conversion contracts, the contractual periodic prepayment or premium, which may be contained in a separate insert and the total of payment for health services and the indemnity or services benefits, if any, which the covered person is obligated to pay;

(19) a description of the MHCP's grievance procedures and method for resolving covered person complaints, including a description of the appeals process available if the MHCP limits or excludes coverage of a treatment or procedure, the address and telephone number to which grievances are to be directed, and a statement identifying the superintendent as an external source with whom grievances may be filed, including the division of insurance contact information, as provided at Paragraph (2) of Subsection A of 13.10.17.24 NMAC, so that the covered person may submit the complaint;

(20) if the MHCP provides prescription drug coverage, the evidence of coverage must convey in clear and concise language:

(a) whether participating providers are restricted to prescribing drugs from a drug formulary;

(b) whether or not brand-name products or specialty drugs require a higher copayment;

(c) the extent, if at all, to which an enrollee will be reimbursed for costs of a drug that is not on the plan's formulary;

(d) how covered persons may obtain, upon request, a complete list of drugs covered by the plan or listed on the MHCP's drug formulary; and

(e) any exclusions or limitations for coverage of “experimental,” “investigational," or "specialty” drugs and definitions of “experimental,” “investigational,” and "specialty" as those terms are used by the MHCP, and in accordance with this chapter;

(21) a list of providers which contains all of the information listed in Subsection D of 13.10.22.8 NMAC, and shall include a statement, if applicable, that providers may be deleted or added within the coverage year;

(22) a statement regarding whether or not participating providers must comply with any specified numbers, targeted averages, or maximum durations of patient visits; and if so, a description of the specific requirements;

(23) a statement reflecting that a covered person will not be liable to a provider for any sums owed to the provider by the MHCP;

(24) language reflecting that the enrollee may be liable for sums owed to a non-contracting provider, except when an enrollee or covered person is mistakenly referred to a non-participating provider by a MHCP provider as discussed in Subsection C of 13.10.22.8 NMAC; and

(25) a statement explaining the covered person's rights and responsibilities as required by 13.10.13.8 NMAC.

B. Toll-free number: The toll-free telephone number referred to in Paragraph (16) of Subsection A of this section shall:

(1) be answered twenty-four (24) hours a day, seven days a week, so that covered persons who need assistance may obtain answers to their questions;

(2) be equipped so that covered persons with non-medical benefit information questions may leave a voice-mail message for the MHCP that the administrative office of the MHCP will answer before 5:00 p.m. on the next business day;

(3) be included on a covered person membership card issued by the MHCP.

C. Electronic communications: MHCPs shall provide web-based or other electronic methods to inform interested covered persons with benefit information and other health care information in accordance with state and federal privacy regulations.

D. Bi-annual updates of provider lists: For MHCPs that require covered persons to select a primary care physician, the MHCP shall provide covered persons with written bi-annual notices of any deletions or additions to the list of primary care physicians in their area, and shall make more recent updated lists available to enrollees or covered persons upon request. The bi-annual notices may be included in other written materials that are sent to covered persons.

E. Current provider lists: The MHCP shall use a current list of providers, including health professionals and facilities, when soliciting individuals or groups for enrollment in the MHCP.

F. Provider information: Upon request of a covered person or prospective covered person, the MHCP shall provide information on participating providers, including their education, training, applicable certification, and any sub-specialty.

G. Termination of provider status:

(1) When an HMO terminates or suspends any contract with a participating provider, the HMO shall notify, in writing, affected covered persons who are current patients of or, where applicable, assigned to the provider, within 30 days. The notice to covered persons shall advise them of their right to continue receiving care from the provider as set forth in 13.10.23.13 NMAC. Current patients are covered persons who have a claim with the HMO related to the provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

(2) The HMO shall assist such affected covered persons in locating and transferring to another similarly qualified provider.

(3) A covered person may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered person, if the covered person has not received comparable notice during this time from the provider.

H. Notice of plan changes: Before issuing any increase in premiums in an individual contract, a MHCP shall provide a 60 day written notice to affected subscribers in the manner the MHCP customarily provides such notice. The MHCP shall also provide in the same manner a 60 day written notice for plan design or plan benefit changes, other than enhanced benefits, in an individual contract. All notices pursuant to this section shall state the reasons for the changes.

I. Disclosure of utilization review procedures: Each MHCP currently doing business in this state shall disclose to the superintendent and to its contracting providers the process by which the MHCP authorizes or

denies health care services rendered by its providers pursuant to the benefits covered by the plan. Any MHCP claiming that such information is proprietary has the burden of showing to the superintendent that the information requested is in fact proprietary. Health care insurers planning to offer a new MHCP in this state must disclose such information to the superintendent prior to when the health care insurer solicits individuals or groups for enrollment in the MHCP. In addition, each MHCP shall make available such information to covered persons and prospective covered persons upon request.

J. Upon request of covered persons and prospective covered persons, the MHCP shall provide copies of its quality assurance plans and patterns of its utilization of services that the MHCP routinely tracks. A MHCP may provide such information through such nationally recognized reporting data bases, such as, for example, the health plan employer data and information set (HEDIS).

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

13.10.23.9 TERMINATION OF COVERAGE:

A. A MHCP shall not cancel the coverage of an enrollee except for "good cause," which, for the purposes of this section means:

(1) failure of the enrollee or subscriber to pay the premiums and other applicable charges for coverage;

(2) material failure to abide by the rules, and/or policies and procedures of the MHCP;

(3) fraud or material misrepresentation affecting coverage;

(4) a reason for cancellation or failure to renew which the superintendent determines is not objectionable.

B. Notwithstanding Subsection A of 13.10.23.8 NMAC, a MHCP shall not cancel an enrollee's coverage for non-payment of copayments if such a cancellation would constitute abandonment of a covered person who is hospitalized and is receiving treatment for a life threatening condition. In addition, a MHCP shall not cancel an enrollee's coverage due to a covered person's refusal to follow a prescribed course of treatment.

C. Before an enrollee's coverage may be terminated by the MHCP, the MHCP must provide written notice of at least 30 calendar days to the enrollee. Notification of cancellation of enrollment must:

(1) be in writing and dated;

(2) state the reason(s) for cancellation, with specific reference to the clause of the MHCP contract giving rise to the right of cancellation;

(3) state that an enrollee cannot be canceled because of health status, need for health care services, race, gender, age, or sexual orientation of covered persons under enrollee's contract;

(4) state that an enrollee who alleges that an enrollment has been canceled or not renewed because of the enrollee's or covered person's health status, need for health care services, race, gender, age, or sexual orientation may request review of the cancellation by the superintendent as set forth in 13.10.17 NMAC;

(5) state that in the event of cancellation by either the enrollee or MHCP, except in the case of fraud or deception in the use of services or facilities of the MHCP or knowingly permitting such fraud or deception by another, the MHCP shall, within 30 calendar days, return to the enrollee or subscriber the pro rata portion of the money paid to the MHCP which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the MHCP; provided, however, that the superintendent may approve other reasonable reimbursement practices;

(6) state the date on which the cancellation becomes effective;

(7) state that receipt by the MHCP of the proper prepaid or periodic payment, including all past due amounts, after cancellation of the contract for nonpayment shall reinstate the contract as though it had never been canceled if such payment is received on or before the due date of the succeeding prepaid or periodic payment; provided, however, that the contract may specify one or more of the following methods by which the MHCP may avoid such reinstatement:

(a) in the notice of cancellation, the MHCP notifies the enrollee that if payment is not received within 15 days of issuance of the notice of cancellation, a new application is required and the conditions under which a new contract will be issued or whether the original contract will be reinstated;

(b) if such payment is received more than 15 calendar days after issuance of the notice of cancellation, the MHCP refunds the payment within 20 business days; or

(c) if such payment is received more than 15 calendar days after issuance of the notice of cancellation, the MHCP issues to the enrollee, within 20 business days of receipt of such payment, a new contract accompanied by a written notice clearly stating the ways in which the new contract differs from the canceled contract, including any difference in benefits or coverage;

(8) state that the MHCP is prohibited from increasing the amount paid by the enrollee, except after a period of at least 30 calendar days from either: 1) the postage paid mailing to the enrollee at the enrollee's address of record with the MHCP; or 2) actual hand delivery to the enrollee of written notice of such proposed increase; and

(9) state that the MHCP is prohibited from decreasing the benefits stated in the contract in any manner, except after a period of at least 30 calendar days from either: 1) the postage paid mailing to the enrollee at the enrollee's address of record with the MHCP; or 2) actual hand delivery to the enrollee of written notice of such proposed change(s).

D. In the event that the MHCP cancels or refuses to renew a managed health care plan contract, or enrollment under the contract, the MHCP shall mail a notice of the cancellation to the enrollee at the enrollee's address of record with the MHCP. However, in the event that the MHCP cancels or refuses to renew a group contract, the MHCP need not mail a notice of cancellation to each enrollee covered by the group plan if:

(1) the plan contract requires the group contract holder to mail promptly any such notice to each enrollee;

(2) the MHCP mails or hand delivers a notice of cancellation to the group contract holder designated in the plan contract, and the MHCP gives a written reminder to the group contract holder of its obligation under the contract; and

(3) the MHCP demonstrates that the group contract holder promptly provided proof to the MHCP of the mailing of a legible true copy of the notice of cancellation to each enrollee at the enrollee's current address and the date the mailing occurred.

E. Each MHCP contract shall provide a notice of cancellation, pursuant to Paragraph (3) of Subsection C of 13.10.23.8 NMAC and will not be effective any sooner than 30 calendar days after the notice is mailed to the enrollee.

F. The terms "cancellation" and "failure to renew," for the purposes of this section do not include a voluntary termination by an enrollee or the termination of a plan or contract which does not contain a renewal provision.

[13.10.23.9 NMAC - Rp, 13.10.13.17 NMAC, 09/01/2009]

13.10.23.10 MEDICAL RECORDS:

A. Transfer of medical records. Each health care insurer shall develop and implement a policy for the transfer of medical records of a covered person whenever the following occur:

(1) change of physician or other health care professional;

(2) disenrollment of enrollee from the managed health care plan; or

(3) other circumstances where requests by covered persons or former covered persons is reasonable.

B. Confidentiality of medical records.

(1) Any data or information pertaining to the diagnosis, treatment, or health of any covered person obtained from the covered person, from any provider, or from any other source, shall be held in confidence as otherwise required or permitted by New Mexico or federal law.

(2) The data or information shall not be disclosed to any person except: 1) to the extent that it may be necessary to carry out the purposes of this rule; 2) upon the express consent of the covered person; 3) pursuant to state or court order for the production of evidence or the discovery thereof; 4) in the event of claim or litigation between a covered person and the health care insurer wherein such data or information is pertinent; or 5) where otherwise required or permitted by New Mexico or federal law.

(3) A health care insurer shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health care insurer is entitled to claim.

C. Maintenance of medical records.

(1) Any medical records directly maintained by the health care insurer shall be organized in a uniform format applicable to all medical records.

(2) The health care insurer shall have policies governing the contents of medical records including maintenance of records by electronic means.

D. Copies of medical records.

(1) Covered persons or their legally authorized representatives shall have a right to inspect and obtain a copy of their medical records maintained by the health care insurer.

(2) Charges for copies of medical records must be based upon actual costs not to exceed the prevailing community market rates. For photocopying, the cost shall be twenty-five cents ($.25) per page or less.

E. Protection of medical records. Medical records maintained by health care insurers shall be protected by health care insurers against loss, destruction, or unauthorized use, and shall be retained for at least 10 years or until the covered person reaches age 21 years, whichever is longer.

F. Destruction of medical records. Destruction of medical records must be such that confidentiality is maintained. Records must be destroyed by shredding, incinerating (where permitted) or by other method of permanent destruction, including purging of medical records from a computer hard disk, server hard disk or other media or disk in accordance with current practices for data deletion. A log must be kept of all charts destroyed, including the patient's name and date of record destruction.

[13.10.23.10 NMAC - Rp, 13.10.13.21 NMAC, 09/01/2009]

13.10.23.11 NONDISCRIMINATION BY HEALTH CARE INSURERS:

A. Guaranteed renewability:

(1) In addition to the guaranteed renewability provisions pertaining to individuals, pursuant to NMSA 1978, Section 59A-23E-19, and under group health plans, pursuant to NMSA 1978, Section 59A-23E-14, health care insurers through managed health care plans are prohibited from establishing rules for continued eligibility of any individual to continue to participate in a health plan based on any of the following:

(a) gender, race, color, national origin, ancestry, religion or marital status;

(b) sexual orientation;

(c) age or the age of any contracting party, or person reasonably expected to benefit from any such contract as a covered person;

(d) health status related factors, and

(e) filing of a grievance or utilization management appeal as permitted by this rule.

(2) Health status related factors include:

(a) medical condition, including both physical and mental illnesses and disability;

(b) claims experience and frequency of use of health care services;

(c) medical history;

(d) genetic information;

(e) evidence of insurability, including conditions arising out of acts of domestic violence.

B. Contract terms and premiums:

(1) A health care insurer issuing a managed health care plan shall comply with the adjusted community rating requirements as to individuals, pursuant to NMSA 1978, Section 59A-18-13.1, and as to small group employers, pursuant to NMSA 1978, Section 59A-23C-5.1.

(2) A health care insurer issuing a managed health care plan is allowed to apply premium, price or charge differentials based on a wellness program to promote health or prevent disease in a managed health care plan, in compliance with 26 CFR Part 54, 29 CFR Part 2590 and 45 CFR Part 146.

C. Providers nondiscrimination: In addition to the provisions of NMSA 1978, Section 59A-57-6, a health care insurer issuing a managed health care plan shall not discriminate against providers on the basis of religion, race, color, national origin, age, sex, marital status, disability, or sexual orientation. Selection of participating providers shall be primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.

D. Genetic information and testing prohibition:

(1) In determining insurability and in processing an application for coverage for health care services under a managed health care plan, health care insurers are prohibited from: 1) requiring an individual seeking coverage to submit to genetic screening or testing; 2) taking into consideration, other than in accordance with this section, the results of genetic screening or testing; 3) making any inquiry to determine the results of genetic screening or testing; or 4) making a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(2) In developing and asking questions regarding medical histories of applicants for coverage under an individual or group managed health care plan, contract, policy, or agreement, no health care insurer shall ask for the results of any genetic screening or testing or ask questions designed to ascertain the results of any genetic screening or testing.

(3) No health care insurer shall cancel or refuse to issue or renew coverage for health care services based on the result of genetic screening or testing or the use of genetic services.

(4) No health care insurer shall deliver, issue for delivery, or renew an individual or group managed health care plan, contract, policy, or agreement in this state that limits benefits based on the results of genetic screening or testing.

(5) A health care insurer may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.

[13.10.23.11 NMAC - Rp, 13.10.13.22 NMAC, 09/01/2009]

13.10.23.12 DECEPTIVE HEALTH CARE INSURER OR MANAGED HEALTH CARE PLAN NAME:

A. A health care insurer or managed health care plan shall not use a deceptive name.

B. A name will be considered deceptive if it unreasonably suggests:

(1) the quality of care provided by the health care insurer or managed health care plan;

(2) that full benefits are provided for health care or a specialized area of health care;

(3) that the cost of benefits to enrollees of the MHCP is lower than the cost of similar benefits purchased elsewhere; and

(4) in any such case where the express or implied representation contained in the name is demonstrably untrue or is not supported by substantial evidence at all times while such name is used by the health care insurer or MHCP.

C. Nothing in this section limits or restricts the superintendent from determining that a health care insurer or MHCP or solicitor firm name is deceptive for reasons other than those stated herein.

D. A change of a health maintenance organization plan name is a "substantial modification" of the HMO for purposes of Section 59A-46-3D NMSA 1978.

[13.10.23.12 NMAC - Rp, 13.10.13.23 NMAC, 09/01/2009]

13.10.23.13 ADVERTISING AND SOLICITATION:

A. Deceptive advertising prohibited. No health care insurer may cause or knowingly permit the use of advertising or solicitation that is untrue or misleading, or may cause or knowingly permit any form of summary of benefits or evidence of coverage which is deceptive.

B. Approval required. All materials, including, but not limited to, solicitation documents and texts of media advertising to be employed by the health care insurer for the purpose of personally soliciting individual or group enrollees shall be submitted, in a form as prescribed by Section 59A-46-5 NMSA 1978 and 13.10.4.18 NMAC, to the superintendent prior to the health care insurer's use of such materials. If such material has not been disapproved by the superintendent within 30 days of its receipt, it shall be deemed approved until such time the superintendent issues a specific disapproval in writing.

C. Information to be included in solicitation. Any solicitation document employed by the health care insurer for the purpose of soliciting individual or group enrollees shall provide a link, contact or other information which would allow the consumer to find the following:

(1) all information necessary to enable a consumer of reasonable understanding, not possessing special knowledge regarding health care coverage, to make an informed choice as to whether or not to enroll with the health care insurer or in the MHCP;

(2) a specific description of the health care services available;

(3) a current list of providers, including health care professionals and facilities; and

(4) the obligations, including financial obligations, required of enrollees who join the MHCP.

D. Deceptive description of benefits. A summary of benefits or evidence of coverage is deceptive if the document taken as a whole, and with consideration given to typography and format, would cause a reasonable person, not possessing special knowledge regarding health care coverage, to expect benefits, services, charges, or other advantages which the MHCP does not provide to covered persons.

E. Inducements prohibited.

(1) No health care insurer shall use monetary or other valuable consideration, engage in misleading or deceptive practices, or make untrue, misleading, or deceptive representations to applicants in order to induce enrollment.

(2) A statement shall be deemed untrue if it does not conform to fact in any respect and would be considered significant to a person contemplating enrollment with a MHCP.

(3) Inducements do not include incentives specified or provided for in the MHCP contract given to covered persons and to promote the delivery of preventive care or other health improvement activities, which include "value added services" described in 8.305.17.9 NMAC.

F. Filing of public advertising. Texts of all media promotional advertising used by the health care insurer solely for the purpose of public advertising shall be filed with the superintendent no later than fifteen (15) days prior to when it first appears in the print, television, electronic, radio, or other medium.

G. Retraction. Any health care insurer that makes untrue or misleading statements may be required by the superintendent to publish a correction or retraction of the untrue or misleading statements in the same medium and with the same prominence in which the original untrue or misleading statements were published or broadcasted.

H. Language used in contracts and advertisements.

(1) All MHCP contracts or forms shall be in English.

(2) If the negotiation by a health care insurer with a subscriber, enrollee or covered person leading up to the effectuation of a MHCP contract is conducted in a language other than English, the health care insurer shall supply to the subscriber, enrollee or covered person a written translation of the contract in the negotiated language, with a verification which certifies that the translation is true, accurate and complete, and accurately reflects the substance of the contract, pursuant to Section 59A-19-6 NMSA 1978. The written translation and verification shall be affixed to and shall become a part of the contract or form. Any such translation and verification shall be provided to the superintendent as part of the filing of the MHCP contract or form. No translation of a MHCP contract form shall be approved by the superintendent unless the translation accurately reflects the substance of the MHCP contract form.

(3) The text of all advertisements by a health care insurer, if printed or broadcast in a language other than English, shall also be available in English and shall be provided to the superintendent upon request.

[13.10.23.13 NMAC - Rp, 13.10.13.26 NMAC, 09/01/2009]

13.10.23.14 CONTINUATION AND TRANSITION OF TREATMENT: Each health care insurer shall offer continuation and transition of treatment to covered persons in compliance with the Insurance Code and applicable rules.

A. If a covered person's health care provider leaves the MHCP's network of providers, the MHCP shall permit the covered person to continue an ongoing course of treatment with the provider for a transitional period.

B. For all covered persons except those addressed Subsection C of 13.10.23.14 NMAC, the transitional period shall continue for a time that is sufficient to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of case, and, in any event, shall not be not less than thirty days.

C. If a covered person has entered the third trimester of pregnancy at the time of the provider's disaffiliation, and the MHCP offers maternity coverage, the transitional period shall include the provision of post-partum care directly related to the delivery.

D. The MHCP will not be required to permit the covered person to continue treatment with the current provider if the provider's disaffiliation with the MHCP was for reasons related to medical competence or professional behavior.

E. For transitional periods exceeding thirty days, the MHCP shall authorize continued care as provided in this section only if the health care provider agrees:

(1) to accept reimbursement from the MHCP at the rates applicable prior to the start of the transitional period as payment in full;

(2) to adhere to the MHCP's quality assurance requirements and to provide to the MHCP necessary medical information related to such care; and

(3) to otherwise adhere to the MHCP's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization and treatment planning approved by the MHCP.

F. If upon the effective date of enrollment a new covered person's health care provider is not a member of the MHCP's provider network, the MHCP shall permit the covered person to continue an ongoing course of treatment with the covered person's current health care provider for a transitional period of time.

G. For covered persons in an ongoing course of treatment, the transitional period shall be sufficient to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of care, and, in any event, shall not be less than thirty days.

H. If a covered person has entered the third trimester of pregnancy at the effective date of enrollment, and the MHCP offers maternity coverage, the transitional period shall include the provision of post-partum care directly related to the delivery.

I. While a covered person is under the care of a provider outside the MHCP's network pursuant to this section, the covered person may receive care from other providers outside the network as ordered by the treating health care professional in consultation with the MHCP. The MHCP shall be obligated to authorize such care and to pay for such services only if the provider furnishing the care to the covered person agrees to accept the conditions described in this section.

[13.10.23.14 NMAC - Rp, 13.10.13.28 NMAC, 09/01/2009]

13.10.23.15 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 and 59A-46-25 NMSA 1978.

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

13.10.23.16 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.

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

HISTORY OF 13.10.23 NMAC:

Pre-NMAC History: none.

History of Repealed Material: [RESERVED]

NMAC History:

Only those applicable portions of 13.10.13 NMAC, Managed Health Care (filed 4/13/2007) were renumbered, amended, and replaced by 13.10.23 NMAC, Managed Health Care Plan Contracting, effective 09/01/2009.