HOUSE BILL 351

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

INTRODUCED BY

JOSE R. ABEYTA

FOR THE HEALTH CARE REFORM COMMITTEE

AN ACT

RELATING TO HEALTH CARE; ENACTING THE MEDICAID MANAGED CARE ACT; PROVIDING REQUIREMENTS FOR MEDICAID MANAGED HEALTH CARE PLANS; IMPOSING A CIVIL PENALTY.

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

Section 1. SHORT TITLE.--This act may be cited as the "Medicaid Managed Care Act".

Section 2. DEFINITIONS.--As used in the Medicaid Managed Care Act:

A. "enrollee", "patient" or "consumer" means an individual who is entitled to receive health care benefits from a managed health care plan;

B. "essential community provider" means a person that provides a significant portion of its health or health-related services to medically needy indigent patients, including uninsured, underserved or special needs populations;

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C. "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;

D. "health care insurer" means a person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, a health maintenance organization, a nonprofit health care plan or a prepaid dental plan;

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

F. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals, health care facilities and essential community providers;

G. "health care services" includes physical health services or community-based mental health or developmental disability services, including services for developmental delay;

H. "managed health care plan" or "plan" means a health benefit plan of a health care insurer or a provider

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service network that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health care insurer. "Managed health care plan" or "plan" includes a plan that provides comprehensive health care services to enrollees on a prepaid, capitated basis and includes the health care services offered by a health maintenance organization, a preferred provider organization, an individual practice organization, a competitive medical plan, an exclusive provider organization, an integrated delivery system, an independent physician-provider organization, a physician hospital-provider organization and a managed care services organization. "Managed health care plan" or "plan" does not include a traditional fee-for-service indemnity plan or a plan that covers only short-term travel, accident-only, limited benefit or specified disease policies;

I. "person" means an individual or other legal entity;

J. "primary health care clinic" means a nonprofit community-based entity established to provide the first level of basic or general health care needs, including diagnostic and treatment services, for residents of a health care underserved area as that area is defined in regulation adopted by the department of health; and

K. "provider service network" means two or more health care providers affiliated for the purpose of providing

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health care services to enrollees on a capitated or similar prepaid, flat-rate basis.

Section 3. MEDICAID MANAGED HEALTH CARE PLAN OPERATIONS--ENROLLMENT RESTRICTIONS--ADMINISTRATIVE ABUSES--PROFITS LIMITED.--

A. Except as otherwise provided in the Medicaid Managed Care Act, the human services department shall monitor each managed health care plan offered through the medicaid program and take all reasonable steps necessary to ensure that each plan operates fairly and efficiently, protects patient interests and fulfills the plan's primary obligation to deliver good quality health care services. The department of health shall be responsible for quality assurance and utilization review oversight of medicaid managed health care plans.

B. No managed health care plan offered through the medicaid program may directly recruit new members for enrollment into the medicaid program. All recruiting and enrollment of eligible persons into the medicaid program shall be arranged directly by the human services department. The department may provide for enrollment directly at hospitals or other health care or government facilities.

C. The human services department shall regulate the marketing activities of managed health care plans offered through the medicaid program and prevent administrative abuses in the operation of the plans.

D. No managed health care plan offered through the

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medicaid program shall be allowed to earn profits in excess of eight and one-half percent. The human services department shall, in cooperation with the department of insurance, adopt regulations to administer the provisions of this subsection. The human services department shall enforce the provisions of this subsection. Any profits earned in excess of eight and one-half percent shall be returned to the human services department, deposited by the department into an appropriate state fund and expended for the purpose of expanding access to health care for the uninsured or underinsured.

Section 4. SPECIALIZED HEALTH CARE PROGRAMS--ESSENTIAL COMMUNITY PROVIDERS.--Until January 1, 2000, no managed health care plan offered through the medicaid program shall offer specialized behavioral or developmental disability health services. The provisions of this section apply to the specialized health care services needed for a person treated for a developmental disability, a developmental delay, a seriously disabling mental illness, a serious emotional disturbance, physical or sexual abuse or neglect, substance abuse or other behavioral health problem as defined in regulation adopted by the department of health. Such specialized behavioral or developmental disability health services shall instead be provided, until January 1, 2000, only by providers, including essential community providers, that have been determined pursuant to regulation adopted by the department of health or the children, youth and families department to be qualified to

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offer specialized behavioral or developmental disability health services.

Section 5. HEALTH CARE PROVIDER PARTICIPATION.--Any health care provider that meets a medicaid managed health care plan's reasonable qualification requirements and that is willing to participate in the plan under its established reasonable terms and conditions shall be allowed to participate in the plan.

Section 6. PRIMARY HEALTH CARE CLINICS PARTICIPATION.--

A. A managed health care plan offered through the medicaid program shall be required to use under reasonable terms and conditions any primary health care clinic that elects to participate in the plan, if the primary health care clinic meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

B. A managed health care plan offered through the medicaid program may not limit the number or location of primary health care clinics that elect to participate in the plan.

C. In providing payments to a primary health care clinic participating in a medicaid managed health care plan, the human services department shall administer a program and provide direct payments to ensure that a primary health care clinic that

was a federally qualified health center in 1996 under applicable federal law receives for at least the same amount and type of services rendered in all subsequent years at least the same amount of total payments under the medicaid program that the primary care clinic received in the calendar year ending December 31, 1996.

D. The human services department and each managed health care plan that contracts with a primary health care clinic shall provide timely payments at least quarterly to each primary care clinic participating in the plan.

Section 7. INDIAN HEALTH SERVICE.--A Native American eligible to receive health care services from the federal Indian health service shall be given the option of participating in a managed health care plan offered through the medicaid program or receiving services directly from the Indian health service. If an eligible Native American chooses to participate in a managed health care plan, the Native American shall at all times retain the option of receiving services directly from the Indian health service. In that event, the managed health care plan shall ensure that the Indian health service receives the same payment it would have received for the services rendered if the patient did not participate in the plan.

Section 8. UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER.--

A. A managed health care plan offered through the medicaid program shall include participation by the university

of New Mexico health sciences center. The human services department shall administer a program to ensure the participation includes delivery of primary care and tertiary care services so that the medicaid patient population served by the university of New Mexico health sciences center remains at least at a level similar to that served by the university of New Mexico health sciences center prior to implementation of the medicaid managed health care program.

B. A managed health care plan offered through the medicaid program shall provide payments to the university of New Mexico health sciences center at rates that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

C. The human services department shall administer a program and cooperate with the university of New Mexico health sciences center to ensure an adequate and diverse patient population necessary to preserve the health sciences center's educational programs. The human services department shall also assure continuity of general support under the state medicaid program to the university of New Mexico health sciences center for medical education and for serving a disproportionately large indigent patient population.

Section 9. PUBLIC NONPROFIT HOSPITALS.--

A. A managed health care plan offered through the

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medicaid program shall be required to use under reasonable terms and conditions any public nonprofit hospital that elects to participate in the plan, if the hospital meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered by any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

B. A managed health care plan offered through the medicaid program may not limit the number or location of public nonprofit hospitals that elect to participate in the plan.

Section 10. LAS VEGAS MEDICAL CENTER.--A managed health care plan offered through the medicaid program shall include participation by the Las Vegas medical center for hospitalized care of mental health patients and other health services the center provides. A plan shall provide payments to the Las Vegas medical center under reasonable terms and conditions. The terms shall be no less favorable than those offered any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

Section 11. AUTHORIZATION FOR MEDICAID MANAGED CARE

CONTRACTS DIRECTLY WITH PUBLIC AGENCIES, HOSPITALS, ESSENTIAL COMMUNITY PROVIDERS AND PROVIDER SERVICE NETWORKS.--In administering the medicaid program or a managed health care system for the program, the human services department may contract directly with a government agency or public body, public nonprofit hospital, the university of New Mexico health sciences center, an essential community provider or a provider service network. In doing so, the human services department is not required to contract with any such entity only through arrangements with a health care insurer.

Section 12. ENFORCEMENT OF THE MEDICAID MANAGED CARE ACT.--

A. The human services department or a person who suffers a loss as a result of a violation of a provision in the Medicaid Managed Care Act may bring an action to recover actual damages or the sum of one hundred dollars ($100), whichever is greater. When the trier of fact finds that the party charged with the violation acted willfully, the court may award up to three times actual damages or three hundred dollars ($300), whichever is greater, to the party complaining of the violation.

B. A person likely to be damaged by a denial of a right protected in the Medicaid Managed Care Act may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damage or intent to violate a right is not required.

C. To protect and enforce an enrollee's or a health

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care provider's rights in a managed health care plan offered through the medicaid program, an enrollee and a health care provider participating in or eligible to participate in a medicaid managed health care plan shall each be treated as a third party beneficiary of the managed health care plan contract between the health care insurer and the party with which the insurer directly contracts. An enrollee or a health care provider may sue to enforce the rights provided in the contract that governs the managed health care plan.

D. The court shall award attorney fees and costs to the party complaining of a violation of a right protected in the Medicaid Managed Care Act if the party prevails substantially in the lawsuit.

E. The relief provided in this section is in addition to other remedies available against the same conduct under the common law or other statutes of this state.

F. In any class action filed under this section, the court may award damages to the named plaintiffs as provided in this section and may award members of the class the actual damages suffered by each member of the class as a result of the unlawful practice.

G. A person shall not be required to complete available grievance procedures or exhaust administrative remedies prior to seeking relief in court regarding a complaint that may be filed under this section.

Section 13. PENALTY.--In addition to any other penalties

provided by law, the secretary of human services may impose a civil administrative penalty of up to twenty-five thousand dollars ($25,000) for each violation of the Medicaid Managed Care Act. An administrative penalty shall be imposed by written order of the secretary after holding a hearing as provided for in the Administrative Procedures Act.

Section 14. REGULATIONS.--The human services department may adopt regulations it deems necessary or appropriate to administer the provisions of the Medicaid Managed Care Act.

Section 15. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1997.

State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE

FIRST SESSION, 1997

February 18, 1997

Mr. Speaker:

Your LABOR AND HUMAN RESOURCES COMMITTEE, to whom has been referred

HOUSE BILL 351

has had it under consideration and reports same with recommendation that it DO NOT PASS, but that

HOUSE LABOR AND HUMAN RESOURCES COMMITTEE
SUBSTITUTE FOR HOUSE BILL 351

DO PASS, amended as follows:

1. On page 12, strike lines 10 through 13 in their entirety and reletter the succeeding subsection accordingly.,

and thence referred to the JUDICIARY COMMITTEE.

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Respectfully submitted,

Rick Miera, Chairman

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 5 For 2 Against

Yes: 5

No: Macko, Roberts

Excused: Marquardt

Absent: None

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State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

February 28, 1997

Mr. Speaker:

Your JUDICIARY COMMITTEE, to whom has been referred

HOUSE LABOR AND HUMAN RESOURCES COMMITTEE SUBSTITUTE FOR HOUSE BILL 351, as amended

has had it under consideration and reports same with recommendation that it DO PASS, amended as follows:

1. On page 5, line 3, after "E." strike the remainder of the line, strike all of lines 4 through 13 and insert in lieu thereof:

"A managed health care plan offered through the medicaid program shall be required to maintain a medical loss ratio of at least ninety percent, so that at a minimum ninety percent of all premium dollars collected are paid for the direct provision of health care services. The department of insurance shall adopt regulations to define the "medical loss ratio" consistent with the provisions of this subsection.",

and thence referred to the APPROPRIATIONS AND FINANCE COMMITTEE.

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Respectfully submitted,

_____

Thomas P. Foy, Chairman

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

Excused: Alwin, King, Larranaga, Mallory, Rios, Sanchez

Absent: None

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HOUSE LABOR AND HUMAN RESOURCES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 351

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

AN ACT

RELATING TO HEALTH CARE; ENACTING THE MEDICAID MANAGED CARE ACT; PROVIDING REQUIREMENTS FOR MEDICAID MANAGED HEALTH CARE PLANS; IMPOSING A CIVIL PENALTY.

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C. "health care facility" means an institution

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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;

D. "health care insurer" means a person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, a health maintenance organization, a nonprofit health care plan or a prepaid dental plan;

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

F. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals, health care facilities and essential community providers;

G. "health care services" includes physical health services or community-based mental health or developmental disability services, including services for developmental delay;

H. "managed health care plan" or "plan" means a health benefit plan of a health care insurer or a provider

service network that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health care insurer. "Managed health care plan" or "plan" does not include a traditional fee-for-service indemnity plan or a plan that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies;

I. "person" means an individual or other legal entity;

J. "primary health care clinic" means a nonprofit community-based entity established to provide the first level of basic or general health care needs, including diagnostic and treatment services, for residents of a health care underserved area as that area is defined in regulation adopted by the department of health; and

K. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to enrollees on a capitated or similar prepaid, flat-rate basis.

Section 3. MEDICAID MANAGED HEALTH CARE PLAN OPERATIONS--ENROLLMENT RESTRICTIONS--ADMINISTRATIVE ABUSES--PROFITS LIMITED.--

A. Except as otherwise provided in the Medicaid Managed Care Act, the human services department shall monitor each managed health care plan offered through the medicaid program and take all reasonable steps necessary to ensure that each plan operates fairly and efficiently, protects patient interests and fulfills the plan's

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primary obligation to deliver good quality health care services. The human services department, in cooperation with the department of health, shall be responsible for quality assurance and utilization review oversight of medicaid managed health care plans.

B. No managed health care plan offered through the medicaid program may directly recruit new members for enrollment into the medicaid program. All enrollment of eligible persons into the medicaid program shall be arranged directly by the human services department.

C. The human services department, through its own offices and employees, joint powers agreements with other state agencies or by contract with one or more brokering agencies independent of any managed health care provider, shall fully inform medicaid eligible persons of their choices for enrollment into a managed health care plan. The department shall ensure that the enrollment process includes adequate time and information for enrollees to make informed choices about a plan. No managed health care plan offered through the medicaid program shall enroll medicaid recipients into its managed health care plan unless the enrollment is in accordance with arrangements approved by the department.

D. The human services department shall regulate the marketing activities of managed health care plans offered through the medicaid program and prevent administrative abuses in the operation of the plans.

E. No managed health care plan offered through the medicaid program shall be allowed to earn profits in excess of eight and one-half percent. The human services department shall, in cooperation with the department of insurance, adopt regulations to administer the provisions of this subsection. The human services department shall enforce the provisions of this subsection. Any profits earned in excess of eight and one-half percent shall be returned to the human services department, deposited by the department into an appropriate state fund and expended for the purpose of expanding access to health care for the uninsured or underinsured.

Section 4. SPECIALIZED HEALTH CARE PROGRAMS--ESSENTIAL COMMUNITY PROVIDERS.--Except as otherwise provided in the Medicaid Managed Care Act, until January 1, 2000, no managed health care plan offered through the medicaid program shall offer specialized behavioral or developmental disability health services. The provisions of this section apply to the specialized health care services needed for a person treated for a developmental disability, a developmental delay, a seriously disabling mental illness, a serious emotional disturbance, physical or sexual abuse or neglect, substance abuse or other behavioral health problem as defined in regulation adopted by the department of health. Such specialized behavioral or developmental disability health services shall instead be provided, until January 1, 2000, only by providers, including essential community providers, that have been

determined pursuant to regulation adopted by the department of health or the children, youth and families department to be qualified to offer specialized behavioral or developmental disability health services.

Section 5. HEALTH CARE PROVIDER PARTICIPATION.--Any health care provider that meets a medicaid managed health care plan's reasonable qualification requirements and that is willing to participate in the plan under its established reasonable terms and conditions shall be allowed to participate in the plan.

Section 6. PRIMARY HEALTH CARE CLINICS PARTICIPATION.--

A. A managed health care plan offered through the medicaid program shall be required to use under reasonable terms and conditions any primary health care clinic that elects to participate in the plan, if the primary health care clinic meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

B. A managed health care plan offered through the medicaid program may not limit the number or location of primary health care clinics that elect to participate in the plan.

C. In providing payments under the medicaid program,

the human services department shall ensure that a primary health care clinic that was or would have qualified as a federally qualified health center in 1996 under the federal act, as defined in 42 U.S.C. Section 1396d(l)(2), shall receive one hundred percent reasonable cost-based reimbursement for services, as was provided in the federal act during 1996 for the centers pursuant to the provisions of 42 U.S.C. Section 1396a(a)(13)(E).

D. In administering the medicaid program, the human services department shall ensure that any managed care program for medicaid, whether implemented through a federal waiver, block grant or otherwise, shall require each health plan participating in the medicaid managed care program to contract with each primary health care clinic in its service area that was or would have qualified as a federally qualified health center in 1996 under the federal act, as defined in 42 U.S.C. Section 1396d(l)(2), for delivery of covered services at terms no less favorable than those offered to other providers in the plan for equivalent services. The department shall provide timely payments at least quarterly to federally qualified health centers to cover the difference between their one hundred percent reasonable costs, as was provided in the federal act during 1996 for the centers pursuant to the provisions of 42 U.S.C. Section 1396a(a)(13)(E), and the payments under medicaid managed care that are received by the federally qualified health centers.

Section 7. INDIAN HEALTH SERVICE.--A Native American

enrolled in a managed health care plan offered through the medicaid program shall be given the option of leaving that plan and receiving services directly from the Indian health service or health services provided by tribes under the federal Indian Self-Determination and Education Assistance Act, the federal urban Indian health program or the federal Indian children's program. If an eligible Native American chooses to participate in a managed health care plan, the Native American shall at all times retain the option of receiving services directly from the Indian health service or health services provided by tribes under the federal Indian Self-Determination and Education Assistance Act, the federal urban Indian health program or the federal Indian children's program. In that event, the managed health care plan shall ensure that the Indian health service receives the same payment it would have received for the services rendered if the patient did not participate in the plan.

Section 8. UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER.--

A. A managed health care plan offered through the medicaid program shall include participation by the university of New Mexico health sciences center. The human services department shall administer a program to ensure the participation includes delivery of primary care and tertiary care services and to attempt to ensure, to the extent permitted by federal law, that the medicaid patient population served by the university of New Mexico

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health sciences center remains at least at a level similar to that served by the university of New Mexico health sciences center prior to implementation of the medicaid managed health care program.

B. A managed health care plan offered through the medicaid program shall provide payments to the university of New Mexico health sciences center at rates that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

C. The human services department shall administer a program and cooperate with the university of New Mexico health sciences center to ensure an adequate and diverse patient population necessary to preserve the health sciences center's educational programs. The human services department shall also assure continuity of general support under the state medicaid program to the university of New Mexico health sciences center for medical education and for serving a disproportionately large indigent patient population.

Section 9. PUBLIC NONPROFIT HOSPITALS.--

A. A managed health care plan offered through the medicaid program shall be required to use under reasonable terms and conditions any public nonprofit hospital that elects to participate in the plan, if the hospital meets all reasonable quality of care and service payment requirements imposed by the

plan. The terms shall be no less favorable than those offered by any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

B. A managed health care plan offered through the medicaid program may not limit the number or location of public nonprofit hospitals that elect to participate in the plan.

Section 10. LAS VEGAS MEDICAL CENTER.--A managed health care plan offered through the medicaid program that offers mental health services shall include participation by the Las Vegas medical center for hospitalized care of mental health patients and other health services the center provides. A plan shall provide payments to the Las Vegas medical center under reasonable terms and conditions. For medicaid eligible populations, the terms shall be no less favorable than those offered any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

Section 11. AUTHORIZATION FOR MEDICAID MANAGED CARE CONTRACTS DIRECTLY WITH PUBLIC AGENCIES, HOSPITALS, ESSENTIAL COMMUNITY PROVIDERS AND PROVIDER SERVICE NETWORKS.--In administering the medicaid program or a managed health care system

for the program, the human services department may contract directly with a government agency or public body, public nonprofit hospital, the university of New Mexico health sciences center, an essential community provider or a provider service network. In doing so, the human services department is not required to contract with any such entity only through arrangements with a health care insurer.

Section 12. ENFORCEMENT OF THE MEDICAID MANAGED CARE ACT.--

A. The human services department or a person who suffers a loss as a result of a violation of a provision in the Medicaid Managed Care Act may bring an action to recover actual damages or the sum of one hundred dollars ($100), whichever is greater. When the trier of fact finds that the party charged with the violation acted willfully, the court may award up to three times actual damages or three hundred dollars ($300), whichever is greater, to the party complaining of the violation.

B. A person likely to be damaged by a denial of a right protected in the Medicaid Managed Care Act may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damage or intent to violate a right is not required.

C. To protect and enforce an enrollee's or a health care provider's rights in a managed health care plan offered through the medicaid program, an enrollee and a health care

provider participating in or eligible to participate in a medicaid managed health care plan shall each be treated as a third party beneficiary of the managed health care plan contract between the health care insurer and the party with which the insurer directly contracts. An enrollee or a health care provider may sue to enforce the rights provided in the contract that governs the managed health care plan.

D. The court shall award attorney fees and costs to the party complaining of a violation of a right protected in the Medicaid Managed Care Act if the party prevails substantially in the lawsuit.

E. The relief provided in this section is in addition to other remedies available against the same conduct under the common law or other statutes of this state.

F. In any class action filed under this section, the court may award damages to the named plaintiffs as provided in this section and may award members of the class the actual damages suffered by each member of the class as a result of the unlawful practice.

G. A person shall not be required to complete available grievance procedures or exhaust administrative remedies prior to seeking relief in court regarding a complaint that may be filed under this section.

Section 13. PENALTY.--In addition to any other penalties provided by law, the secretary of human services may impose a civil

administrative penalty of up to twenty-five thousand dollars ($25,000) for each violation of the Medicaid Managed Care Act. An administrative penalty shall be imposed by written order of the secretary after holding a hearing as provided for in the Public Assistance Appeals Act.

Section 14. REGULATIONS.--The human services department may adopt regulations it deems necessary or appropriate to administer the provisions of the Medicaid Managed Care Act.

Section 15. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1997.

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 16, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

HOUSE LABOR AND HUMAN RESOURCES
COMMITTEE SUBSTITUTE FOR
HOUSE BILL 351, as amended

has had it under consideration and reports same with recommendation that it DO PASS.

Respectfully submitted,

_____
Shannon Robinson, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 5 For 0 Against

Yes: 5

No: 0

Excused: Boitano, Garcia, Ingle, Rodarte

Absent: None

H0351PA1