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HOUSE BILL 350

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

INTRODUCED BY

EDWARD C. SANDOVAL

FOR THE HEALTH CARE REFORM COMMITTEE
AND THE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO INSURANCE; ENACTING THE PATIENT PROTECTION ACT;
PROVIDING PROTECTIONS FOR PERSONS IN MANAGED HEALTH CARE PLANS;
APPLYING PATIENT PROTECTIONS TO MEDICAID MANAGED CARE; IMPOSING
A CIVIL PENALTY; AMENDING AND ENACTING SECTIONS OF THE NMSA
1978; MAKING AN APPROPRIATION.

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

Section 1. A new section of the New Mexico Insurance Code
is enacted to read:

"[NEW MATERIAL] SHORT TITLE. -- Sections 1 through 11 of
this act may be cited as the "Patient Protection Act". "

Section 2. A new section of the New Mexico Insurance Code
is enacted to read:

"[NEW MATERIAL] PURPOSE OF ACT. -- The purpose of the
Patient Protection Act is to regulate aspects of health

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[bracketed material] = delete

1 insurance by specifying patient and provider rights and
2 confirming and clarifying the authority of the department to
3 adopt regulations to provide protections to persons enrolled in
4 managed health care plans. The insurance protections should
5 ensure that managed health care plans treat patients fairly and
6 fulfill their primary obligation to deliver good quality health
7 care services. "

8 Section 3. A new section of the New Mexico Insurance Code
9 is enacted to read:

10 "[NEW MATERIAL] DEFINITIONS. --As used in the Patient
11 Protection Act:

12 A. "continuous quality improvement" means an ongoing
13 and systematic effort to measure, evaluate and improve a managed
14 health care plan's operations in order to improve continually
15 the quality of health care services provided to enrollees;

16 B. "covered person", "enrollee", "patient" or
17 "consumer" means an individual who is entitled to receive health
18 care benefits from a managed health care plan;

19 C. "department" means the insurance department;

20 D. "emergency care" means a health care procedure,
21 treatment or service delivered to a covered person after the
22 sudden onset of what appears to be a medical condition that
23 manifests itself by symptoms of sufficient severity that the
24 absence of immediate medical attention could be expected by a
25 reasonable layperson to result in jeopardy to a person's health,

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1 serious impairment of bodily functions, serious dysfunction of a
2 body part or disfigurement to a person;

3 E. "health care facility" means an institution
4 providing health care services, including a hospital or other
5 licensed inpatient center; an ambulatory surgical or treatment
6 center; a skilled nursing center; a residential treatment
7 center; a home health agency; a diagnostic, laboratory or
8 imaging center; and a rehabilitation or other therapeutic health
9 setting;

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

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

18 H. "health care provider" or "provider" means a
19 person that is licensed or otherwise authorized by the state to
20 furnish health care services and includes health care
21 professionals and health care facilities;

22 I. "health care services" includes physical health
23 or community-based mental health or developmental disability
24 services, including services for developmental delay;

25 J. "managed health care plan" or "plan" means a

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1 health benefit plan of a health care insurer or a provider
2 service network that either requires a covered person to use, or
3 creates incentives, including financial incentives, for a
4 covered person to use health care providers managed, owned,
5 under contract with or employed by the health care insurer. A
6 managed health care plan includes a plan that provides health
7 care services to enrollees on a prepaid, capitated basis and
8 includes the health care services offered by a health
9 maintenance organization, preferred provider organization,
10 individual practice organization, a competitive medical plan, an
11 exclusive provider organization, an integrated delivery system,
12 an independent physician-provider organization, a physician
13 hospital-provider organization or a managed care services
14 organization. "Managed health care plan" or "plan" does not
15 include a traditional fee-for-service indemnity plan or a plan
16 that covers only short-term travel, accident-only, limited
17 benefit or specified disease policies;

18 K. "person" means an individual or other legal
19 entity;

20 L. "point-of-service plan" or "open plan" means a
21 managed health care plan that allows enrollees to use health
22 care providers other than providers under direct contract with
23 the plan, even if the plan provides incentives, including
24 financial incentives, for covered persons to use the plan's
25 designated participating providers;

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1 M "primary health care clinic" means a nonprofit
2 community-based entity established to provide the first level of
3 basic or general health care needs, including diagnostic and
4 treatment services, for residents of a health care underserved
5 area as that area is defined in regulation adopted by the
6 department of health and includes an entity that serves
7 primarily low-income populations;

8 N. "provider service network" means two or more
9 health care providers affiliated for the purpose of providing
10 health care services to covered persons on a capitated or
11 similar prepaid flat-rate basis;

12 O. "superintendent" means the superintendent of
13 insurance; and

14 P. "utilization review" means a system for reviewing
15 the appropriate and efficient allocation of health care
16 services, including hospitalization, given or proposed to be
17 given to a patient or group of patients. "

18 Section 4. A new section of the New Mexico Insurance Code
19 is enacted to read:

20 " [NEW MATERIAL] PATIENT RIGHTS-- DISCLOSURES-- RIGHTS TO
21 BASIC AND COMPREHENSIVE HEALTH CARE SERVICES-- GRIEVANCE
22 PROCEDURE-- UTILIZATION REVIEW PROGRAM - CONTINUOUS QUALITY
23 PROGRAM --

24 A. Each covered person enrolled in a managed health
25 care plan has the right to be treated fairly. A managed health

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[bracketed material] = delete

1 care plan shall deliver good quality and appropriate health care
2 services to enrollees. The department shall adopt regulations
3 to implement the provisions of the Patient Protection Act and
4 shall monitor and oversee a managed health care plan to ensure
5 that each covered person enrolled in a plan is treated fairly
6 and is accorded the rights necessary or appropriate to protect
7 patient interests. In adopting regulations to implement the
8 provisions of Subparagraphs (a) and (b) of Paragraph (3) and
9 Paragraphs (5) and (6) of Subsection B of this section regarding
10 health care standards and specialists, utilization review
11 programs and continuous quality improvement programs, the
12 department shall cooperate with and seek advice from the
13 department of health.

14 B. The regulations adopted by the department to
15 protect patient rights shall provide at a minimum that:

16 (1) a managed health care plan shall provide
17 oral and written summaries, policies and procedures that
18 explain, prior to or at the time of enrollment and at subsequent
19 periodic times as appropriate, in a clear, conspicuous and
20 readily understandable form, full and fair disclosure of the
21 plan's benefits, terms, conditions, prior authorization
22 requirements, enrollee financial responsibility for payments,
23 grievance procedures, appeal rights and the patient rights
24 generally available to all covered persons;

25 (2) a managed health care plan shall provide

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1 each covered person with appropriate basic and comprehensive
2 health care services that are reasonably accessible and
3 available in a timely manner to each covered person;

4 (3) in providing the right to reasonably
5 accessible health care services that are available in a timely
6 manner, a managed health care plan shall ensure that:

7 (a) the plan offers sufficient numbers
8 and types of safe and adequately staffed health care providers
9 at reasonable hours of service to meet the health needs of the
10 enrollee population, including providers that are culturally
11 appropriate for the enrollee population;

12 (b) health care providers that are
13 specialists may act as primary care providers for patients with
14 special health needs;

15 (c) reasonable access is provided to
16 out-of-network health care providers; and

17 (d) emergency care is immediately
18 available without prior authorization requirements, and
19 appropriate out-of-network emergency care is not subject to
20 additional costs;

21 (4) a managed health care plan shall adopt and
22 implement a prompt and fair grievance procedure for resolving
23 patient complaints and addressing patient questions and concerns
24 regarding any aspect of the plan, including the quality of and
25 access to health care, the choice of health care provider or

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1 treatment and the adequacy of the plan's provider network. The
2 grievance procedures shall notify patients of their statutory
3 appeal rights, including the option of seeking immediate relief
4 in court, and shall provide for a prompt and fair appeal of a
5 plan's decision to the superintendent, including special
6 provisions to govern emergency appeals to the superintendent in
7 health emergencies;

8 (5) a managed health care plan shall adopt and
9 implement a comprehensive utilization review program. The
10 procedures and standards used in a plan's utilization review
11 program to approve or deny care shall be disclosed to an
12 affected enrollee. The decision to approve or deny care to a
13 patient shall be made in a timely manner, and the final decision
14 shall be made by a qualified health care professional. A plan's
15 utilization review program shall ensure that enrollees have
16 proper access to health care services, including referrals to
17 necessary specialists. A decision made in a plan's utilization
18 review program shall be subject to the plan's grievance
19 procedure and appeal to the superintendent; and

20 (6) a managed health care plan shall adopt and
21 implement a continuous quality improvement program that monitors
22 the quality and appropriateness of the health care services
23 provided by the plan. "

24 Section 5. A new section of the New Mexico Insurance Code
25 is enacted to read:

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1 " [NEW MATERIAL] CONSUMER ASSISTANCE-- CONSUMER ADVISORY
2 BOARDS-- OMBUDSMAN OFFICE-- REPORTS TO CONSUMERS-- SUPERINTENDENT' S
3 ORDERS TO PROTECT CONSUMERS. --

4 A. Each health care insurer that offers a managed
5 health care plan shall establish and adequately staff a consumer
6 assistance office. The purpose of the consumer assistance
7 office is to respond to consumer questions and concerns and
8 assist patients in exercising their rights and protecting their
9 interests as consumers of health care.

10 B. Each health care insurer that offers a managed
11 health care plan shall establish a consumer advisory board. The
12 board shall meet at least quarterly and shall advise the insurer
13 about the plan's general operations from the perspective of the
14 enrollee as a consumer of health care. The board shall also
15 oversee the plan's consumer assistance office.

16 C. The department shall establish and adequately
17 staff a managed care ombudsman office. The purpose of the
18 managed care ombudsman office shall be to assist patients in
19 exercising their rights and help advocate for and protect
20 patient interests. The department's managed care ombudsman
21 office shall work in conjunction with each insurer's consumer
22 assistance office and shall independently evaluate the
23 effectiveness of the insurer's consumer assistance office. The
24 department's managed care ombudsman office may require an
25 insurer's consumer assistance office to adopt measures to ensure

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1 that the plan operates effectively to protect patient rights and
2 inform consumers of the information to which they are entitled.

3 D. The department shall prepare an annual report
4 assessing the operations of managed health care plans subject to
5 the department's oversight, including information about consumer
6 complaints.

7 E. A person may file a complaint with the
8 superintendent regarding a violation of the Patient Protection
9 Act. Prior to issuing any remedial order regarding violations
10 of the Patient Protection Act or its regulations, the
11 superintendent shall hold a hearing in accordance with the
12 provisions of Chapter 59A, Article 4 NMSA 1978. The
13 superintendent may issue any order he deems necessary or
14 appropriate, including ordering the delivery of appropriate
15 care, to protect consumers and enforce the provisions of the
16 Patient Protection Act. The superintendent shall adopt special
17 procedures to govern the submission of emergency appeals to him
18 in health emergencies. "

19 Section 6. A new section of the New Mexico Insurance Code
20 is enacted to read:

21 " [NEW MATERIAL] FAIRNESS TO HEALTH CARE PROVIDERS--GAG
22 RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS. --

23 A. No managed health care plan may:

24 (1) adopt a gag rule or practice that prohibits
25 a health care provider from discussing a treatment option with

1 an enrollee even if the plan does not approve of the option;

2 (2) offer a health care provider inducements,
3 other than those inherent in a capitation payment system, to
4 reduce or limit medically necessary health care services; or

5 (3) require a health care provider to violate
6 the ethical duties of his profession or place his license in
7 jeopardy.

8 B. A health care insurer that proposes to terminate
9 a health care provider from the insurer's managed health care
10 plan shall explain in writing the rationale for its proposed
11 termination and deliver reasonable advance written notice to the
12 provider prior to the proposed effective date of the
13 termination.

14 C. A managed health care plan shall adopt and
15 implement a prompt and fair grievance procedure for resolving
16 health care provider complaints and addressing provider
17 questions and concerns regarding any aspect of the plan,
18 including the quality of and access to health care, the choice
19 of health care provider or treatment and the adequacy of the
20 plan's provider network. The grievance procedures shall notify
21 providers of their statutory appeal rights, including the option
22 of seeking immediate relief in court, and shall provide for a
23 prompt and fair appeal of a plan's decision to the
24 superintendent, including special provisions to govern emergency
25 appeals to the superintendent in health emergencies. "

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1 Section 7. A new section of the New Mexico Insurance Code
2 is enacted to read:

3 " [NEW MATERIAL] POINT-OF-SERVICE OPTION PLAN. -- The
4 department may require a health care insurer that offers a
5 managed health care plan to include a point-of-service or open
6 plan option. "

7 Section 8. A new section of the New Mexico Insurance Code
8 is enacted to read:

9 " [NEW MATERIAL] ADMINISTRATIVE COSTS AND BENEFIT COSTS
10 DISCLOSURES. -- The department shall adopt regulations to ensure
11 that both the administrative costs and the direct costs of
12 providing health care services of each managed health care plan
13 are fully and fairly disclosed to consumers in a uniform manner
14 that allows meaningful cost comparisons among plans. "

15 Section 9. A new section of the New Mexico Insurance Code
16 is enacted to read:

17 " [NEW MATERIAL] PRIVATE REMEDIES TO ENFORCE PATIENT AND
18 PROVIDER INSURANCE RIGHTS-- ENROLLEE AND PROVIDER AS THIRD-PARTY
19 BENEFICIARIES TO ENFORCE THEIR RIGHTS-- EXHAUSTION OF REMEDIES
20 NOT REQUIRED. --

21 A. A violation of a patient's rights to health care
22 services in the regulation of insurance as protected pursuant to
23 the provisions of the Patient Protection Act shall be deemed an
24 act of professional malpractice.

25 B. A person who suffers a loss as a result of a

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1 violation of a right protected pursuant to the provisions of the
2 Patient Protection Act, its regulations or a managed health care
3 plan may bring an action to recover actual damages or the sum of
4 one hundred dollars (\$100), whichever is greater. When the
5 trier of fact finds that the party charged with the violation
6 acted willfully, the court may award up to three times actual
7 damages or three hundred dollars (\$300), whichever is greater,
8 to the party complaining of the violation.

9 C. A person likely to be damaged by a denial of a
10 right protected pursuant to the provisions of the Patient
11 Protection Act, its regulations or a managed health care plan
12 may be granted an injunction under the principles of equity and
13 on terms that the court considers reasonable. Proof of monetary
14 damage or intent to violate a right is not required.

15 D. To protect and enforce an enrollee's or a health
16 care provider's rights in a managed health care plan, an
17 individual enrollee and a health care provider participating in
18 or eligible to participate in a managed health care plan shall
19 each be treated as a third-party beneficiary of the managed
20 health care plan contract between the health care insurer and
21 the party with which the health care insurer directly contracts.
22 An individual enrollee or a health care provider may sue to
23 enforce the rights provided in the contract that governs the
24 managed health care plan.

25 E. The court shall award attorney fees and costs to

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1 the party complaining of a violation of a right protected
2 pursuant to the provisions of the Patient Protection Act, its
3 regulations or a managed health care plan if the party
4 substantially prevails in the lawsuit.

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

8 G. In any class action filed pursuant to this
9 section, the court may award damages to the named plaintiffs as
10 provided in this section and may award members of the class the
11 actual damages suffered by each member of the class as a result
12 of the unlawful practice.

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

17 Section 10. A new section of the New Mexico Insurance Code
18 is enacted to read:

19 " [NEW MATERIAL] APPLICATION OF ACT TO MEDICAID PROGRAM --
20 The provisions of the Patient Protection Act apply to the
21 medicaid program operation in the state. A managed health care
22 plan offered through the medicaid program shall grant enrollees
23 and providers the same rights and protections as are granted to
24 enrollees and providers in any other managed health care plan
25 subject to the provisions of the Patient Protection Act. "

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1 Section 11. A new section of the New Mexico Insurance Code
2 is enacted to read:

3 "[NEW MATERIAL] PENALTY. --In addition to any other
4 penalties provided by law, a civil administrative penalty of up
5 to twenty-five thousand dollars (\$25,000) may be imposed for
6 each violation of the Patient Protection Act. An administrative
7 penalty shall be imposed by written order of the superintendent
8 made after holding a hearing as provided for in Chapter 59A,
9 Article 4 NMSA 1978. "

10 Section 12. Section 59A-1-16 NMSA 1978 (being Laws 1984,
11 Chapter 127, Section 16) is amended to read:

12 "59A-1-16. EXEMPTED FROM CODE. --In addition to
13 organizations and businesses otherwise exempt, the Insurance
14 Code shall not apply [as] to:

15 A. a labor organization [~~which~~] that, incidental
16 only to operations as a labor organization, issues benefit
17 certificates to ~~members~~ or maintains funds to assist ~~members~~ and
18 their families in times of illness, injury or need, and not for
19 profit;

20 B. the credit union share insurance corporation, as
21 identified in [~~Article 58-12~~] Chapter 58, Article 12 NMSA 1978,
22 and similar corporations and funds for protection of depositors,
23 shareholders or creditors of financial institutions and
24 businesses other than insurers; or

25 C. the risk management division of the general

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1 services department [~~of finance and administration of New~~
2 ~~Mexico~~] or [as] to insurance of public property or public risks
3 by any agency of government not otherwise engaged in the
4 business of insurance, except the provisions of the Patient
5 Protection Act shall apply to the risk management division and
6 any managed health care plan it offers."

7 Section 13. Section 59A-46-30 NMSA 1978 (being Laws 1993,
8 Chapter 266, Section 29) is amended to read:

9 "59A-46-30. STATUTORY CONSTRUCTION AND RELATIONSHIP TO
10 OTHER LAWS. --

11 A. The provisions of the Insurance Code other than
12 Chapter 59A, Article 46 NMSA 1978 shall not apply to health
13 maintenance organizations except as expressly provided in the
14 Insurance Code and that article. To the extent reasonable and
15 not inconsistent with the provisions of that article, the
16 following articles and provisions of the Insurance Code shall
17 also apply to health maintenance organizations, their promoters,
18 sponsors, directors, officers, employees, agents, solicitors and
19 other representatives [~~and~~]. For the purposes of such
20 applicability, a health maintenance organization may [~~therein~~]
21 be referred to as an "insurer":

- 22 (1) Chapter 59A, Article 1 NMSA 1978;
- 23 (2) Chapter 59A, Article 2 NMSA 1978;
- 24 (3) Chapter 59A, Article 3 NMSA 1978;
- 25 (4) Chapter 59A, Article 4 NMSA 1978;

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- 1 (5) Subsection C of Section 59A-5-22 NMSA 1978;
- 2 (6) Sections 59A-6-2 through 59A-6-4 and
- 3 59A-6-6 NMSA 1978;
- 4 (7) Chapter 59A, Article 8 NMSA 1978;
- 5 (8) Chapter 59A, Article 10 NMSA 1978;
- 6 (9) Section 59A-12-22 NMSA 1978;
- 7 (10) Chapter 59A, Article 16 NMSA 1978;
- 8 (11) Chapter 59A, Article 18 NMSA 1978;
- 9 (12) Chapter 59A, Article 19 NMSA 1978;
- 10 ~~(13) Section 59A-22-14 NMSA 1978;~~
- 11 [~~(13)~~] (14) Chapter 59A, Article 23B NMSA 1978;
- 12 [~~(14)~~] (15) Sections 59A-34-9 through
- 13 59A-34-13, 59A-34-23, 59A-34-36 and 59A-34-37 NMSA 1978; [~~and~~
- 14 ~~(15)~~] (16) Chapter 59A, Article 37 NMSA 1978;
- 15 and
- 16 (17) the Patient Protection Act.

17 B. Solicitation of enrollees by a health maintenance
18 organization granted a certificate of authority, or its
19 representatives, shall not be construed as violating any
20 provision of law relating to solicitation or advertising by
21 health professionals, but health professionals shall be
22 individually subject to the laws, rules, regulations and ethical
23 provisions governing their individual professions.

24 C. Any health maintenance organization authorized
25 under the provisions of the Health Maintenance Organization Law

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1 shall not be deemed to be practicing medicine and shall be
2 exempt from the provisions of laws relating to the practice of
3 medicine. "

4 Section 14. Section 59A-47-33 NMSA 1978 (being Laws 1984,
5 Chapter 127, Section 879.32, as amended by Laws 1994, Chapter
6 64, Section 10 and also by Laws 1994, Chapter 75, Section 34) is
7 amended to read:

8 "59A-47-33. OTHER PROVISIONS APPLICABLE. --The provisions
9 of the Insurance Code other than Chapter 59A, Article 47 NMSA
10 1978 shall not apply to health care plans except as expressly
11 provided in the Insurance Code and that article. To the extent
12 reasonable and not inconsistent with the provisions of that
13 article, the following articles and provisions of the Insurance
14 Code shall also apply to health care plans, their promoters,
15 sponsors, directors, officers, employees, agents, solicitors and
16 other representatives; and, for the purposes of such
17 applicability, a health care plan may ~~[therein]~~ be referred to
18 as an "insurer":

- 19 A. Chapter 59A, Article 1 NMSA 1978;
- 20 B. Chapter 59A, Article 2 NMSA 1978;
- 21 C. Chapter 59A, Article 4 NMSA 1978;
- 22 D. Subsection C of Section 59A-5-22 NMSA 1978;
- 23 E. Sections 59A-6-2 through 59A-6-4 and
24 59A-6-6 NMSA 1978;
- 25 F. Section 59A-7-11 NMSA 1978;

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- 1 G. Chapter 59A, Article 8 NMSA 1978;
- 2 H. Chapter 59A, Article 10 NMSA 1978;
- 3 I. Section 59A-12-22 NMSA 1978;
- 4 J. Chapter 59A, Article 16 NMSA 1978;
- 5 K. Chapter 59A, Article 18 NMSA 1978;
- 6 L. Chapter 59A, Article 19 NMSA 1978;
- 7 M. Subsections B through E of Section
- 8 59A-22-5 NMSA 1978;
- 9 N. Section 59A-22-14 NMSA 1978;
- 10 [~~N.~~] Q. Section 59A-22-34.1 NMSA 1978;
- 11 [~~Q.~~] P. Section 59A-22-39 NMSA 1978;
- 12 [~~P.~~] Q. Section 59A-22-40 NMSA 1978;
- 13 [~~Q.~~] R. Sections 59A-34-9 through 59A-34-13 [~~NMSA~~
- 14 ~~1978~~] and [~~Section~~] 59A-34-23 NMSA 1978;
- 15 [~~R.~~] S. Chapter 59A, Article 37 NMSA 1978, except
- 16 Section 59A-37-7 NMSA 1978; [~~and~~
- 17 ~~S.~~] T. Section 59A-46-15 NMSA 1978; and
- 18 U. the Patient Protection Act. "

19 Section 15. APPROPRIATION. -- Two hundred four thousand nine
20 hundred dollars (\$204,900) is appropriated from the general fund
21 to the department of insurance for expenditure in fiscal year
22 1998 to pay salaries and benefits and other costs necessary to
23 establish a managed care ombudsman office and administer the
24 provisions of the Patient Protection Act. Any unexpended or
25 unencumbered balance remaining at the end of fiscal year 1998

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1 shall revert to the general fund.

2 Section 16. EFFECTIVE DATE. --The effective date of the
3 provisions of this act is July 1, 1997.

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**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 350

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 350

DO PASS, and thence referred to the JUDICIARY
COMMITTEE.

HOUSE LABOR AND HUMAN RESOURCES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 350

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

AN ACT

RELATING TO INSURANCE; ENACTING THE PATIENT PROTECTION ACT;
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. 117001.3

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3 ensure that managed health care plans treat patients fairly and
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5 care services. "

6 Section 3. A new section of the New Mexico Insurance Code
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12 health care plan's operations in order to improve continually
13 the quality of health care services provided to enrollees;

14 B. "covered person", "enrollee", "patient" or
15 "consumer" means an individual who is entitled to receive health
16 care benefits from a managed health care plan;

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18 D. "emergency care" means a health care procedure,
19 treatment or service delivered to a covered person after the
20 sudden onset of what appears to be a medical condition that
21 manifests itself by symptoms of sufficient severity that the
22 absence of immediate medical attention could be expected by a
23 reasonable layperson to result in jeopardy to a person's health,
24 serious impairment of bodily functions, serious dysfunction of a
25 body part or disfigurement to a person;

. 117001.3

1 E. "health care facility" means an institution
2 providing health care services, including a hospital or other
3 licensed inpatient center; an ambulatory surgical or treatment
4 center; a skilled nursing center; a residential treatment center; a
5 home health agency; a diagnostic, laboratory or imaging center; and
6 a rehabilitation or other therapeutic health setting;

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

11 G. "health care professional" means a physician or
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13 licensed, certified or otherwise authorized by the state to provide
14 health care services consistent with state law;

15 H. "health care provider" or "provider" means a person
16 that is licensed or otherwise authorized by the state to furnish
17 health care services and includes health care professionals and
18 health care facilities;

19 I. "health care services" includes physical health or
20 community-based mental health or developmental disability services,
21 including services for developmental delay;

22 J. "managed health care plan" or "plan" means a health
23 benefit plan of a health care insurer or a provider service network
24 that either requires a covered person to use, or creates
25 incentives, including financial incentives, for a covered person to

1 use health care providers managed, owned, under contract with or
2 employed by the health care insurer. "Managed health care plan" or
3 "plan" does not include a traditional fee-for-service indemnity
4 plan or a plan that covers only short-term travel, accident-only,
5 limited benefit, student health plan or specified disease policies;

6 K. "person" means an individual or other legal entity;

7 L. "point-of-service plan" or "open plan" means a
8 managed health care plan that allows enrollees to use health care
9 providers other than providers under direct contract with the plan,
10 even if the plan provides incentives, including financial
11 incentives, for covered persons to use the plan's designated
12 participating providers;

13 M "primary health care clinic" means a nonprofit
14 community-based entity established to provide the first level of
15 basic or general health care needs, including diagnostic and
16 treatment services, for residents of a health care underserved area
17 as that area is defined in regulation adopted by the department of
18 health and includes an entity that serves primarily low-income
19 populations;

20 N. "provider service network" means two or more health
21 care providers affiliated for the purpose of providing health care
22 services to covered persons on a capitated or similar prepaid flat-
23 rate basis;

24 O. "superintendent" means the superintendent of
25 insurance; and

1 P. "utilization review" means a system for reviewing
2 the appropriate and efficient allocation of health care services,
3 including hospitalization, given or proposed to be given to a
4 patient or group of patients. "

5 Section 4. A new section of the New Mexico Insurance Code is
6 enacted to read:

7 "NEW MATERIAL PATIENT RIGHTS--DISCLOSURES--RIGHTS TO BASIC
8 AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE PROCEDURE--
9 UTILIZATION REVIEW PROGRAM-CONTINUOUS QUALITY PROGRAM --

10 A. Each covered person enrolled in a managed health
11 care plan has the right to be treated fairly. A managed health
12 care plan shall deliver good quality and appropriate health care
13 services to enrollees. The department shall adopt regulations to
14 implement the provisions of the Patient Protection Act and shall
15 monitor and oversee a managed health care plan to ensure that each
16 covered person enrolled in a plan is treated fairly and is accorded
17 the rights necessary or appropriate to protect patient interests.
18 In adopting regulations to implement the provisions of
19 Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5) and
20 (6) of Subsection B of this section regarding health care standards
21 and specialists, utilization review programs and continuous quality
22 improvement programs, the department shall cooperate with and seek
23 advice from the department of health.

24 B. The regulations adopted by the department to protect
25 patient rights shall provide at a minimum that:

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Underscored material = new
[bracketed material] = delete

1 (1) a managed health care plan shall provide oral
2 and written summaries, policies and procedures that explain, prior
3 to or at the time of enrollment and at subsequent periodic times as
4 appropriate, in a clear, conspicuous and readily understandable
5 form, full and fair disclosure of the plan's benefits, terms,
6 conditions, prior authorization requirements, enrollee financial
7 responsibility for payments, grievance procedures, appeal rights
8 and the patient rights generally available to all covered persons;

9 (2) a managed health care plan shall provide each
10 covered person with appropriate basic and comprehensive health care
11 services that are reasonably accessible and available in a timely
12 manner to each covered person;

13 (3) in providing the right to reasonably
14 accessible health care services that are available in a timely
15 manner, a managed health care plan shall ensure that:

16 (a) the plan offers sufficient numbers and
17 types of safe and adequately staffed health care providers at
18 reasonable hours of service to meet the health needs of the
19 enrollee population, and takes into account cultural aspects of the
20 enrollee population;

21 (b) health care providers that are
22 specialists may act as primary care providers for patients with
23 chronic medical conditions, provided the specialists offer all
24 reasonable primary care services required by a managed health care
25 plan;

1 (c) reasonable access is provided to
2 out-of-network health care providers; and

3 (d) emergency care is immediately available
4 without prior authorization requirements, and appropriate out-of-
5 network emergency care is not subject to additional costs;

6 (4) a managed health care plan shall adopt and
7 implement a prompt and fair grievance procedure for resolving
8 patient complaints and addressing patient questions and concerns
9 regarding any aspect of the plan, including the quality of and
10 access to health care, the choice of health care provider or
11 treatment and the adequacy of the plan's provider network. The
12 grievance procedures shall notify patients of their statutory
13 appeal rights, including the option of seeking immediate relief in
14 court, and shall provide for a prompt and fair appeal of a plan's
15 decision to the superintendent, including special provisions to
16 govern emergency appeals to the superintendent in health
17 emergencies;

18 (5) a managed health care plan shall adopt and
19 implement a comprehensive utilization review program. The basis of
20 a decision to approve or deny care shall be disclosed to an
21 affected enrollee. The decision to approve or deny care to a
22 patient shall be made in a timely manner, and the final decision
23 shall be made by a qualified health care professional. A plan's
24 utilization review program shall ensure that enrollees have proper
25 access to health care services, including referrals to necessary

1 specialists. A decision made in a plan's utilization review
2 program shall be subject to the plan's grievance procedure and
3 appeal to the superintendent; and

4 (6) a managed health care plan shall adopt and
5 implement a continuous quality improvement program that monitors
6 the quality and appropriateness of the health care services
7 provided by the plan. "

8 Section 5. A new section of the New Mexico Insurance Code is
9 enacted to read:

10 "[NEW MATERIAL] CONSUMER ASSISTANCE-- CONSUMER ADVISORY
11 BOARDS-- OMBUDSMAN OFFICE-- REPORTS TO CONSUMERS-- SUPERINTENDENT' S
12 ORDERS TO PROTECT CONSUMERS. --

13 A. Each health care insurer that offers a managed
14 health care plan shall establish and adequately staff a consumer
15 assistance office. The purpose of the consumer assistance office
16 is to respond to consumer questions and concerns and assist
17 patients in exercising their rights and protecting their interests
18 as consumers of health care.

19 B. Each health care insurer that offers a managed
20 health care plan shall establish a consumer advisory board. The
21 board shall meet at least quarterly and shall advise the insurer
22 about the plan's general operations from the perspective of the
23 enrollee as a consumer of health care. The board shall also
24 oversee the plan's consumer assistance office.

25 C. The department shall establish and adequately staff

1 a managed care ombudsman office, either within the department or by
 2 contract. The purpose of the managed care ombudsman office shall
 3 be to assist patients in exercising their rights and help advocate
 4 for and protect patient interests. The department's managed care
 5 ombudsman office shall work in conjunction with each insurer's
 6 consumer assistance office and shall independently evaluate the
 7 effectiveness of the insurer's consumer assistance office. The
 8 department's managed care ombudsman office may require an insurer's
 9 consumer assistance office to adopt measures to ensure that the
 10 plan operates effectively to protect patient rights and inform
 11 consumers of the information to which they are entitled.

12 D. The department shall prepare an annual report
 13 assessing the operations of managed health care plans subject to
 14 the department's oversight, including information about consumer
 15 complaints.

16 E. A person may file a complaint with the
 17 superintendent regarding a violation of the Patient Protection Act.
 18 Prior to issuing any remedial order regarding violations of the
 19 Patient Protection Act or its regulations, the superintendent shall
 20 hold a hearing in accordance with the provisions of Chapter 59A,
 21 Article 4 NMSA 1978. The superintendent may issue any order he
 22 deems necessary or appropriate, including ordering the delivery of
 23 appropriate care, to protect consumers and enforce the provisions
 24 of the Patient Protection Act. The superintendent shall adopt
 25 special procedures to govern the submission of emergency appeals to

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1 him in health emergencies. "

2 Section 6. A new section of the New Mexico Insurance Code is
3 enacted to read:

4 " [NEW MATERIAL] FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES
5 PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS. --

6 A. No managed health care plan may:

7 (1) adopt a gag rule or practice that prohibits a
8 health care provider from discussing a treatment option with an
9 enrollee even if the plan does not approve of the option;

10 (2) offer a health care provider inducements,
11 other than those inherent in a capitation payment system, to reduce
12 or limit medically necessary health care services; or

13 (3) require a health care provider to violate the
14 ethical duties of his profession or place his license in jeopardy.

15 B. A health care insurer that proposes to terminate a
16 health care provider from the insurer's managed health care plan
17 shall explain in writing the rationale for its proposed termination
18 and deliver reasonable advance written notice to the provider prior
19 to the proposed effective date of the termination.

20 C. A managed health care plan shall adopt and implement
21 a prompt and fair grievance procedure for resolving health care
22 provider complaints and addressing provider questions and concerns
23 regarding any aspect of the plan, including the quality of and
24 access to health care, the choice of health care provider or
25 treatment and the adequacy of the plan's provider network. The

1 grievance procedures shall notify providers of their statutory
2 appeal rights, including the option of seeking immediate relief in
3 court, and shall provide for a prompt and fair appeal of a plan's
4 decision to the superintendent, including special provisions to
5 govern emergency appeals to the superintendent in health
6 emergencies. "

7 Section 7. A new section of the New Mexico Insurance Code is
8 enacted to read:

9 "[NEW MATERIAL] POINT-OF-SERVICE OPTION PLAN. --The
10 department may require a health care insurer that offers a
11 point-of-service plan or open plan to include in any managed health
12 care plan it offers an option for a point-of-service plan or open
13 plan. "

14 Section 8. A new section of the New Mexico Insurance Code is
15 enacted to read:

16 "[NEW MATERIAL] ADMINISTRATIVE COSTS AND BENEFIT COSTS
17 DISCLOSURES. --The department shall adopt regulations to ensure that
18 both the administrative costs and the direct costs of providing
19 health care services of each managed health care plan are fully and
20 fairly disclosed to consumers in a uniform manner that allows
21 meaningful cost comparisons among plans. "

22 Section 9. A new section of the New Mexico Insurance Code is
23 enacted to read:

24 "[NEW MATERIAL] PRIVATE REMEDIES TO ENFORCE PATIENT AND
25 PROVIDER INSURANCE RIGHTS-- ENROLLEE AS THIRD-PARTY BENEFICIARY TO

Underscored material = new
[bracketed material] = delete

1 ENFORCE RIGHTS. --

2 A. A person who suffers a loss as a result of a
3 violation of a right protected pursuant to the provisions of the
4 Patient Protection Act, its regulations or a managed health care
5 plan may bring an action to recover actual damages or the sum of
6 one hundred dollars (\$100), whichever is greater.

7 B. A person likely to be damaged by a denial of a right
8 protected pursuant to the provisions of the Patient Protection Act,
9 its regulations or a managed health care plan may be granted an
10 injunction under the principles of equity and on terms that the
11 court considers reasonable. Proof of monetary damage or intent to
12 violate a right is not required.

13 C. To protect and enforce an enrollee's rights in a
14 managed health care plan, an individual enrollee participating in
15 or eligible to participate in a managed health care plan shall be
16 treated as a third-party beneficiary of the managed health care
17 plan contract between the health care insurer and the party with
18 which the health care insurer directly contracts. An individual
19 enrollee may sue to enforce the rights provided in the contract
20 that governs the managed health care plan.

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

24 E. In any class action filed pursuant to this section,
25 the court may award damages to the named plaintiffs as provided in

1 this section and may award members of the class the actual damages
2 suffered by each member of the class as a result of the unlawful
3 practice. "

4 Section 10. A new section of the New Mexico Insurance Code
5 is enacted to read:

6 "[NEW MATERIAL] APPLICATION OF ACT TO MEDICAID PROGRAM --The
7 provisions of the Patient Protection Act apply to the medicaid
8 program operation in the state. A managed health care plan offered
9 through the medicaid program shall grant enrollees and providers
10 the same rights and protections as are granted to enrollees and
11 providers in any other managed health care plan subject to the
12 provisions of the Patient Protection Act. "

13 Section 11. A new section of the New Mexico Insurance Code
14 is enacted to read:

15 "[NEW MATERIAL] PENALTY. --In addition to any other penalties
16 provided by law, a civil administrative penalty of up to twenty-
17 five thousand dollars (\$25,000) may be imposed for each violation
18 of the Patient Protection Act. An administrative penalty shall be
19 imposed by written order of the superintendent made after holding a
20 hearing as provided for in Chapter 59A, Article 4 NMSA 1978. "

21 Section 12. Section 59A-1-16 NMSA 1978 (being Laws 1984,
22 Chapter 127, Section 16) is amended to read:

23 "59A-1-16. EXEMPTED FROM CODE. --In addition to organizations
24 and businesses otherwise exempt, the Insurance Code shall not apply
25 [as] to:

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Underscored material = new
[bracketed material] = delete

1 A. a labor organization [~~which~~] that, incidental only
2 to operations as a labor organization, issues benefit certificates
3 to members or maintains funds to assist members and their families
4 in times of illness, injury or need, and not for profit;

5 B. the credit union share insurance corporation, as
6 identified in [~~Article 58-12~~] Chapter 58, Article 12 NMSA 1978, and
7 similar corporations and funds for protection of depositors,
8 shareholders or creditors of financial institutions and businesses
9 other than insurers; or

10 C. the risk management division of the general services
11 department [~~of finance and administration of New Mexico~~] or [as] to
12 insurance of public property or public risks by any agency of
13 government not otherwise engaged in the business of insurance,
14 except the provisions of the Patient Protection Act shall apply to
15 the risk management division and any managed health care plan it
16 offers. "

17 Section 13. Section 59A-46-30 NMSA 1978 (being Laws 1993,
18 Chapter 266, Section 29) is amended to read:

19 "59A-46-30. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER
20 LAWS. --

21 A. The provisions of the Insurance Code other than
22 Chapter 59A, Article 46 NMSA 1978 shall not apply to health
23 maintenance organizations except as expressly provided in the
24 Insurance Code and that article. To the extent reasonable and not
25 inconsistent with the provisions of that article, the following

1 articles and provisions of the Insurance Code shall also apply to
 2 health maintenance organizations, their promoters, sponsors,
 3 directors, officers, employees, agents, solicitors and other
 4 representatives [~~and~~]. For the purposes of such applicability, a
 5 health maintenance organization may [~~therein~~] be referred to as an
 6 "insurer":

- 7 (1) Chapter 59A, Article 1 NMSA 1978;
- 8 (2) Chapter 59A, Article 2 NMSA 1978;
- 9 (3) Chapter 59A, Article 3 NMSA 1978;
- 10 (4) Chapter 59A, Article 4 NMSA 1978;
- 11 (5) Subsection C of Section 59A-5-22 NMSA 1978;
- 12 (6) Sections 59A-6-2 through 59A-6-4 and 59A-6-6

13 NMSA 1978;

- 14 (7) Chapter 59A, Article 8 NMSA 1978;
- 15 (8) Chapter 59A, Article 10 NMSA 1978;
- 16 (9) Section 59A-12-22 NMSA 1978;
- 17 (10) Chapter 59A, Article 16 NMSA 1978;
- 18 (11) Chapter 59A, Article 18 NMSA 1978;
- 19 (12) Chapter 59A, Article 19 NMSA 1978;
- 20 (13) Section 59A-22-14 NMSA 1978;

21 [~~(13)~~] (14) Chapter 59A, Article 23B NMSA 1978;

22 [~~(14)~~] (15) Sections 59A-34-9 through

23 59A-34-13, 59A-34-23, 59A-34-36 and 59A-34-37 NMSA 1978; [~~and~~

24 ~~(15)~~] (16) Chapter 59A, Article 37 NMSA 1978; and

25 (17) the Patient Protection Act.

1 B. Solicitation of enrollees by a health maintenance
2 organization granted a certificate of authority, or its
3 representatives, shall not be construed as violating any provision
4 of law relating to solicitation or advertising by health
5 professionals, but health professionals shall be individually
6 subject to the laws, rules, regulations and ethical provisions
7 governing their individual professions.

8 C. Any health maintenance organization authorized under
9 the provisions of the Health Maintenance Organization Law shall not
10 be deemed to be practicing medicine and shall be exempt from the
11 provisions of laws relating to the practice of medicine."

12 Section 14. Section 59A-47-33 NMSA 1978 (being Laws 1984,
13 Chapter 127, Section 879.32, as amended by Laws 1994, Chapter 64,
14 Section 10 and also by Laws 1994, Chapter 75, Section 34) is
15 amended to read:

16 "59A-47-33. OTHER PROVISIONS APPLICABLE. --The provisions of
17 the Insurance Code other than Chapter 59A, Article 47 NMSA 1978
18 shall not apply to health care plans except as expressly provided
19 in the Insurance Code and that article. To the extent reasonable
20 and not inconsistent with the provisions of that article, the
21 following articles and provisions of the Insurance Code shall also
22 apply to health care plans, their promoters, sponsors, directors,
23 officers, employees, agents, solicitors and other representatives;
24 and, for the purposes of such applicability, a health care plan may
25 [~~therein~~] be referred to as an "insurer":

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- 1 A. Chapter 59A, Article 1 NMSA 1978;
- 2 B. Chapter 59A, Article 2 NMSA 1978;
- 3 C. Chapter 59A, Article 4 NMSA 1978;
- 4 D. Subsection C of Section 59A-5-22 NMSA 1978;
- 5 E. Sections 59A-6-2 through 59A-6-4 and
- 6 59A-6-6 NMSA 1978;
- 7 F. Section 59A-7-11 NMSA 1978;
- 8 G. Chapter 59A, Article 8 NMSA 1978;
- 9 H. Chapter 59A, Article 10 NMSA 1978;
- 10 I. Section 59A-12-22 NMSA 1978;
- 11 J. Chapter 59A, Article 16 NMSA 1978;
- 12 K. Chapter 59A, Article 18 NMSA 1978;
- 13 L. Chapter 59A, Article 19 NMSA 1978;
- 14 M. Subsections B through E of Section
- 15 59A-22-5 NMSA 1978;
- 16 N. Section 59A-22-14 NMSA 1978;
- 17 [~~N.~~] Q. Section 59A-22-34.1 NMSA 1978;
- 18 [~~0.~~] P. Section 59A-22-39 NMSA 1978;
- 19 [~~P.~~] Q. Section 59A-22-40 NMSA 1978;
- 20 [~~Q.~~] R. Sections 59A-34-9 through 59A-34-13 [~~NMSA 1978~~]
- 21 and [~~Section~~] 59A-34-23 NMSA 1978;
- 22 [~~R.~~] S. Chapter 59A, Article 37 NMSA 1978, except
- 23 Section 59A-37-7 NMSA 1978; [~~and~~
- 24 ~~S.~~] T. Section 59A-46-15 NMSA 1978; and
- 25 U. the Patient Protection Act. "

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
LABOR AND HUMAN RESOURCES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 350
has had it under consideration and reports same with
recommendation that it DO PASS, and thence referred to the
APPROPRIATIONS AND FINANCE COMMITTEE.

Respectfully submitted,

Thomas P. Foy, Chairman

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

HLC/HB 350

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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, Stewart

Absent: None

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FORTY-THIRD LEGISLATURE
FIRST SESSION

March 10, 1997

HOUSE FLOOR AMENDMENT number 1 to HOUSE LABOR AND HUMAN RESOURCES
COMMITTEE SUBSTITUTE
FOR HOUSE BILL 350, as amended

Amendment sponsored by Representative Edward C. Sandoval

1. Strike House Appropriations and Finance Committee

Amendment 2.

2. On page 10, line 12, after "(2)" strike the remainder of the
line, strike all of lines 13 and 14 and inset in lieu thereof:

"include in any of its contracts with health care providers any
provisions that offer an inducement, financial or otherwise, to provide
less than medically necessary services to an enrollee; or".

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FORTY-THIRD LEGISLATURE
FIRST SESSION

HLC/HB 350

HF/HB 350, aa

Page 44

Edward C. Sandoval

Adopted _____

Not Adopted _____

(Chief Clerk)

(Chief Clerk)

Date _____

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 17, 1997

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred
HOUSE LABOR AND HUMAN RESOURCES COMMITTEE SUBSTITUTE
FOR HOUSE BILL 350, as amended

has had it under consideration and reports same with recommendation that
it DO PASS, and thence referred to the FINANCE COMMITTEE.

Respectfully submitted,

Shannon Robinson, Chairman

Adopted _____ Not Adopted _____
(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 3 For 2 Against

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HLC/HB 350

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Yes: 3
No: Adair, Boitano
Excused: Vernon, Rodarte, Garcia, Ingle
Absent: None

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FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 19, 1997

Mr. President:

Your FINANCE COMMITTEE, to whom has been referred

HOUSE LABOR AND HUMAN RESOURCES SUBSTITUTE FOR
HOUSE BILL 350, as amended

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

Respectfully submitted,

Ben D. Altamirano, Chairman

Adopted _____

Not Adopted _____

(Chief Clerk)

(Chief Clerk)

Underscored material = new
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HLC/HB 350

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Date _____

The roll call vote was 6 For 0 Against

Yes: 6

No: None

Excused: Aragon, Eisenstadt, Ingle, McKibben, Smith

Absent: None

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Underscored material = new
[bracketed material] = delete