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HOUSE BILL 361

43RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 1998

INTRODUCED BY

EDWARD C. SANDOVAL

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.**

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
4 in managed health care plans. The insurance protections
5 should ensure that managed health care plans treat patients
6 fairly and fulfill their primary obligation to deliver good
7 quality health care services. "

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

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

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

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

20 C. "department" means the insurance department;

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

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1 reasonable layperson to result in jeopardy to a person's
2 health, serious impairment of bodily functions, serious
3 dysfunction of a body part or disfigurement to a person;

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

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

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

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

24 I. "health care services" includes physical health
25 or community-based mental health or developmental disability

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1 services, including services for developmental delay;

2 J. "managed health care plan" or "plan" means a
3 health benefit plan of a health care insurer or a provider
4 service network that either requires a covered person to use,
5 or creates incentives, including financial incentives, for a
6 covered person to use health care providers managed, owned,
7 under contract with or employed by the health care insurer.
8 "Managed health care plan" or "plan" does not include a
9 traditional fee-for-service indemnity plan or a plan that
10 covers only short-term travel, accident-only, limited benefit,
11 student health plan or specified disease policies;

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

14 L. "point-of-service plan" or "open plan" means a
15 managed health care plan that allows enrollees to use health
16 care providers other than providers under direct contract with
17 the plan, even if the plan provides incentives, including
18 financial incentives, for covered persons to use the plan's
19 designated participating providers;

20 M "primary health care clinic" means a nonprofit
21 community-based entity established to provide the first level
22 of basic or general health care needs, including diagnostic
23 and treatment services, for residents of a health care
24 underserved area as that area is defined in regulation adopted
25 by the department of health and includes an entity that serves

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1 primarily low-income populations;

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

6 O. "superintendent" means the superintendent of
7 insurance; and

8 P. "utilization review" means a system for
9 reviewing the appropriate and efficient allocation of health
10 care services, including hospitalization, given or proposed to
11 be given to a patient or group of patients. "

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

14 "[NEW MATERIAL] PATIENT RIGHTS-- DISCLOSURES-- RIGHTS TO
15 BASIC AND COMPREHENSIVE HEALTH CARE SERVICES-- GRIEVANCE
16 PROCEDURE-- UTILIZATION REVIEW PROGRAM- CONTINUOUS QUALITY
17 PROGRAM --

18 A. Each covered person enrolled in a managed
19 health care plan has the right to be treated fairly. A
20 managed health care plan shall deliver good quality and
21 appropriate health care services to enrollees. The department
22 shall adopt regulations to implement the provisions of the
23 Patient Protection Act and shall monitor and oversee a managed
24 health care plan to ensure that each covered person enrolled
25 in a plan is treated fairly and is accorded the rights

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1 necessary or appropriate to protect patient interests. In
2 adopting regulations to implement the provisions of
3 Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5)
4 and (6) of Subsection B of this section regarding health care
5 standards and specialists, utilization review programs and
6 continuous quality improvement programs, the department shall
7 cooperate with and seek advice from the department of health.

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

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

19 (2) a managed health care plan shall provide
20 each covered person with appropriate basic and comprehensive
21 health care services that are reasonably accessible and
22 available in a timely manner to each covered person;

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

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1 (a) the plan offers sufficient numbers
2 and types of safe and adequately staffed health care providers
3 at reasonable hours of service to meet the health needs of the
4 enrollee population, and takes into account cultural aspects
5 of the enrollee population;

6 (b) health care providers that are
7 specialists may act as primary care providers for patients
8 with chronic medical conditions, provided the specialists
9 offer all reasonable primary care services required by a
10 managed health care plan;

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

13 (d) emergency care is immediately
14 available without prior authorization requirements, and
15 appropriate out-of-network emergency care is not subject to
16 additional costs;

17 (4) a managed health care plan shall adopt
18 and implement a prompt and fair grievance procedure for
19 resolving patient complaints and addressing patient questions
20 and concerns regarding any aspect of the plan, including the
21 quality of and access to health care, the choice of health
22 care provider or treatment and the adequacy of the plan's
23 provider network. The grievance procedures shall notify
24 patients of their statutory appeal rights, including the
25 option of seeking immediate relief in court, and shall provide

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1 for a prompt and fair appeal of a plan's decision to the
2 superintendent, including special provisions to govern
3 emergency appeals to the superintendent in health emergencies;

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

16 (6) a managed health care plan shall adopt
17 and implement a continuous quality improvement program that
18 monitors the quality and appropriateness of the health care
19 services provided by the plan. "

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

22 "[NEW MATERIAL] CONSUMER ASSISTANCE--CONSUMER ADVISORY
23 BOARDS--OMBUDSMAN OFFICE--REPORTS TO CONSUMERS--
24 SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS.--

25 A. Each health care insurer that offers a managed

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1 health care plan shall establish and adequately staff a
2 consumer assistance office. The purpose of the consumer
3 assistance office is to respond to consumer questions and
4 concerns and assist patients in exercising their rights and
5 protecting their interests as consumers of health care.

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

13 C. The department shall establish and adequately
14 staff a managed care ombudsman office, either within the
15 department or by contract. The purpose of the managed care
16 ombudsman office shall be to assist patients in exercising
17 their rights and help advocate for and protect patient
18 interests. The department's managed care ombudsman office
19 shall work in conjunction with each insurer's consumer
20 assistance office and shall independently evaluate the
21 effectiveness of the insurer's consumer assistance office.
22 The department's managed care ombudsman office may require an
23 insurer's consumer assistance office to adopt measures to
24 ensure that the plan operates effectively to protect patient
25 rights and inform consumers of the information to which they

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1 are entitled.

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

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

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

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

22 A. No managed health care plan may:

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

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1 the option;

2 (2) include in any of its contracts with
3 health care providers any provisions that offer on inducement,
4 financial or otherwise, to provide less than medically
5 necessary services to an enrollee; or

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

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

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

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1 emergency appeals to the superintendent in health
2 emergencies. "

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

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

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

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

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

20 "[NEW MATERIAL] PRIVATE REMEDIES TO ENFORCE PATIENT AND
21 PROVIDER INSURANCE RIGHTS-- ENROLLEE AS THIRD-PARTY BENEFICIARY
22 TO ENFORCE RIGHTS. --

23 A. A person who suffers a loss as a result of a
24 violation of a right protected pursuant to the provisions of
25 the Patient Protection Act, its regulations or a managed

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1 health care plan may bring an action to recover actual damages
2 or the sum of one hundred dollars (\$100), whichever is
3 greater.

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

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

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

22 E. In any class action filed pursuant to this
23 section, the court may award damages to the named plaintiffs
24 as provided in this section and may award members of the class
25 the actual damages suffered by each member of the class as a

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1 result of the unlawful practice. "

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

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

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

14 "[NEW MATERIAL] PENALTY. --In addition to any other
15 penalties provided by law, a civil administrative penalty of
16 up to twenty-five thousand dollars (\$25,000) may be imposed
17 for each violation of the Patient Protection Act. An
18 administrative penalty shall be imposed by written order of
19 the superintendent made after holding a hearing as provided
20 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
24 organizations and businesses otherwise exempt, the Insurance
25 Code shall not apply [as] to:

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

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

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

18 Section 13. Section 59A-46-30 NMSA 1978 (being Laws
19 1993, Chapter 266, Section 29) is amended to read:

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

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

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1 not inconsistent with the provisions of that article, the
2 following articles and provisions of the Insurance Code shall
3 also apply to health maintenance organizations, their
4 promoters, sponsors, directors, officers, employees, agents,
5 solicitors and other representatives [~~and~~]. For the purposes
6 of such applicability, a health maintenance organization may
7 [~~therein~~] be referred to as an "insurer":

- 8 (1) Chapter 59A, Article 1 NMSA 1978;
- 9 (2) Chapter 59A, Article 2 NMSA 1978;
- 10 (3) Chapter 59A, Article 3 NMSA 1978;
- 11 (4) Chapter 59A, Article 4 NMSA 1978;
- 12 (5) Subsection C of Section 59A-5-22 NMSA
13 1978;
- 14 (6) Sections 59A-6-2 through 59A-6-4 and
15 59A-6-6 NMSA 1978;
- 16 (7) Chapter 59A, Article 8 NMSA 1978;
- 17 (8) Chapter 59A, Article 10 NMSA 1978;
- 18 (9) Section 59A-12-22 NMSA 1978;
- 19 (10) Chapter 59A, Article 16 NMSA 1978;
- 20 (11) Chapter 59A, Article 18 NMSA 1978;
- 21 (12) Chapter 59A, Article 19 NMSA 1978;
- 22 (13) Section 59A-22-14 NMSA 1978;
- 23 [~~(13)~~] (14) Chapter 59A, Article 23B NMSA
24 1978;
- 25 [~~(14)~~] (15) Sections 59A-34-9 through

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1 59A-34-13, 59A-34-23, 59A-34-36 and 59A-34-37 NMSA 1978; [and
2 ~~(15)~~] (16) Chapter 59A, Article 37 NMSA 1978;
3 and
4 (17) the Patient Protection Act.

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

12 C. Any health maintenance organization authorized
13 under the provisions of the Health Maintenance Organization
14 Law shall not be deemed to be practicing medicine and shall be
15 exempt from the provisions of laws relating to the practice of
16 medicine. "

17 Section 14. Section 59A-47-33 NMSA 1978 (being Laws
18 1984, Chapter 127, Section 879.32, as amended by Laws 1994,
19 Chapter 64, Section 10 and also by Laws 1994, Chapter 75,
20 Section 34) is amended to read:

21 "59A-47-33. OTHER PROVISIONS APPLICABLE. -- The provisions
22 of the Insurance Code other than Chapter 59A, Article 47 NMSA
23 1978 shall not apply to health care plans except as expressly
24 provided in the Insurance Code and that article. To the
25 extent reasonable and not inconsistent with the provisions of

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1 that article, the following articles and provisions of the
2 Insurance Code shall also apply to health care plans, their
3 promoters, sponsors, directors, officers, employees, agents,
4 solicitors and other representatives; and, for the purposes of
5 such applicability, a health care plan may [~~therein~~] be
6 referred to as an "insurer":

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

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~~[Q.]~~ R. Sections 59A-34-9 through 59A-34-13 [~~NMSA~~
~~1978~~] and [~~Section~~] 59A-34-23 NMSA 1978;

~~[R.]~~ S. Chapter 59A, Article 37 NMSA 1978, except
Section 59A-37-7 NMSA 1978; [~~and~~

~~S.]~~ T. Section 59A-46-15 NMSA 1978; and

U. the Patient Protection Act. "

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

1 FORTY-THIRD LEGISLATURE
2 SECOND SESSION, 1998
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6 February 4, 1998
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9 Mr. Speaker:
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11 Your RULES AND ORDER OF BUSINESS COMMITTEE, to
12 whom has been referred
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14
15 HOUSE BILL 361
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17 has had it under consideration and finds same to be GERMANE
18 in accordance with constitutional provisions.
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21 Respectfully submitted,
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R. David Pederson, Chairman

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

Date _____

The roll call vote was 8 For 0 Against

Yes: 8

Excused: Hobbs, Lujan, Nicely, Russell, Ryan, Sanchez, Williams,

SM

Absent: None

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1 FORTY-THIRD LEGISLATURE

2 SECOND SESSION, 1998

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6 February 10, 1998

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8 Mr. Speaker:

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10 Your BUSINESS AND INDUSTRY COMMITTEE, to whom has
11 been referred

12
13 HOUSE BILL 361

14
15 has had it under consideration and reports same with
16 recommendation that it DO NOT PASS, but that

17 HOUSE BUSINESS AND INDUSTRY COMMITTEE SUBSTITUTE

18 FOR

19 HOUSE BILL 361

20
21 DO PASS, and thence referred to the JUDICIARY
22 COMMITTEE.

FORTY-THIRD LEGISLATURE
SECOND SESSION, 1998

HVEC/HB 361

Page 23

Respectfully submitted,

Fred Luna, Chairman

Adopted _____

Not Adopted _____

(Chief Clerk)

(Chief Clerk)

Date _____

The roll call vote was 11 For 0 Against

Yes: 11

Excused: Olguin

Absent: Getty

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HOUSE BUSINESS AND INDUSTRY COMMITTEE SUBSTITUTE FOR
HOUSE BILL 361

43RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 1998

AN ACT

RELATING TO INSURANCE; ENACTING THE PATIENT PROTECTION ACT;
PROVIDING PROTECTIONS FOR PERSONS IN MANAGED HEALTH CARE
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in managed health care plans. The insurance protections should ensure that managed health care plans treat patients fairly and arrange for the delivery of good quality services."

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

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

C. "department" means the insurance department;

D. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

E. "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;

. 123025. 2

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

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

9 H. "health care provider" or "provider" means a
10 person that is licensed or otherwise authorized by the state to
11 furnish health care services and includes health care
12 professionals and health care facilities;

13 I. "health care services" includes, to the extent
14 offered by the plan, physical health or community-based mental
15 health or developmental disability services, including services
16 for developmental delay;

17 J. "managed health care plan" or "plan" means a
18 health care insurer or a provider service network when offering a
19 benefit that either requires a covered person to use, or creates
20 incentives, including financial incentives, for a covered person
21 to use health care providers managed, owned, under contract with
22 or employed by the health care insurer or provider service
23 network. "Managed health care plan" or "plan" does not include a
24 health care insurer or provider service network offering a
25 traditional fee-for-service indemnity benefit or a benefit that
26 covers only short-term travel, accident-only, limited benefit,
27 student health plan or specified disease policies;

K. "person" means an individual or other legal

1 entity;

2 L. "point-of-service plan" or "open plan" means a
3 managed health care plan that allows enrollees to use health care
4 providers other than providers under direct contract with or
5 employed by the plan, even if the plan provides incentives,
6 including financial incentives, for covered persons to use the
7 plan's designated participating providers;

8 M "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 similar
11 prepaid flat-rate basis that hold a certificate of authority
12 pursuant to the Provider Service Network Act;

13 N. "superintendent" means the superintendent of
14 insurance; and

15 O. "utilization review" means a system for reviewing
16 the appropriate and efficient allocation of health care services
17 given or proposed to be 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
care plan shall arrange for the delivery of good quality and
appropriate health care services to enrollees as defined in the
particular subscriber agreement. The department shall adopt

. 123025. 2

Underscored material = new
[bracketed material] = delete

1 regulations to implement the provisions of the Patient Protection
2 Act and shall monitor and oversee a managed health care plan to
3 ensure that each covered person enrolled in a plan is treated
4 fairly and in accordance with the requirements of the Patient
5 Protection Act. In adopting regulations to implement the
6 provisions of Subparagraphs (a) and (b) of Paragraph (3) and
7 Paragraphs (5) and (6) of Subsection B of this section regarding
8 health care standards and specialists, utilization review
9 programs and continuous quality improvement programs, the
10 department shall cooperate with and seek advice from the
11 department of health.

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

14 (1) prior to or at the time of enrollment, a
15 managed health care plan shall provide a summary of benefits and
16 exclusions, premium information and a provider listing; within a
17 reasonable time after enrollment and at subsequent periodic times
18 as appropriate, a managed health care plan shall provide written
19 material that contains, in a clear, conspicuous and readily
20 understandable form, a full and fair disclosure of the plan's
21 benefits, limitations, exclusions, conditions of eligibility,
22 prior authorization requirements, enrollee financial
23 responsibility for payments, grievance procedures, appeal rights
24 and the patients' rights generally available to all covered
25 persons;

(2) a managed health care plan shall provide
health care services that are reasonably accessible and available
in a timely manner to each covered person;

1 (3) in providing reasonably accessible health
2 care services that are available in a timely manner, a managed
3 health care plan shall ensure that:

4 (a) the plan offers sufficient numbers and
5 types of qualified and adequately staffed health care providers
6 at reasonable hours of service to provide health care services to
7 the plan's enrollees;

8 (b) health care providers that are
9 specialists may act as primary care providers for patients with
10 chronic medical conditions, provided the specialists offer all
11 basic health care services that are required of them by a managed
12 health care plan;

13 (c) reasonable access is provided to
14 out-of-network health care providers if medically necessary
15 covered services are not reasonably available through
16 participating health care providers or if necessary to provide
17 continuity of care during brief transition periods;

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

22 (e) the plan, through provider selection,
23 provider education, the provision of additional resources or
24 other means, reasonably addresses the cultural and linguistic
25 diversity of its enrollee population;

(4) a managed health care plan shall adopt and
implement a prompt and fair grievance procedure for resolving
patient complaints and addressing patient questions and concerns

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1 regarding any aspect of the plan, including the quality of and
2 access to health care, the choice of health care provider or
3 treatment and the adequacy of the plan's provider network. The
4 grievance procedure shall notify patients of their right to
5 obtain review by the plan, their right to obtain review by the
6 superintendent, their right to expedited review of emergent
7 utilization decisions and their rights under the Patient
8 Protection Act;

9 (5) a managed health care plan shall adopt and
10 implement a comprehensive utilization review program. The basis
11 of a decision to deny care shall be disclosed to an affected
12 enrollee. The decision to approve or deny care to an enrollee
13 shall be made in a timely manner, and the final decision shall be
14 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 procedure
19 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:

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

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

7 B. Each managed health care plan shall establish a
 8 consumer advisory board. The board shall meet at least quarterly
 9 and shall advise the plan about the plan's general operations
 10 from the perspective of the enrollee as a consumer of health
 11 care. The board shall also review the operations of and be
 12 advisory to the plan's consumer assistance office.

13 C. The department shall establish and adequately
 14 staff a managed care ombudsman office, either within the
 15 department or by contract. The purpose of the managed care
 16 ombudsman office shall be to assist patients in exercising their
 17 rights and help advocate for and protect patient interests. The
 18 department's managed care ombudsman office shall work in
 19 conjunction with each plan's consumer assistance office and shall
 20 independently evaluate the effectiveness of the plan's consumer
 21 assistance office. The department's managed care ombudsman
 22 office may require a plan's consumer assistance office to adopt
 23 measures to ensure that the plan operates effectively to protect
 24 patient rights and inform consumers of the information to which
 25 they are entitled.

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

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1 complaints.

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

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

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

18 A. No managed health care plan may:

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

22 (2) include in any of its contracts with health
23 care providers any provisions that offer an inducement, financial
24 or otherwise, to provide less than medically necessary services
25 to an enrollee; or

(3) require a health care provider to violate
any recognized fiduciary duty of his profession or place his
license in jeopardy.

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[bracketed material] = delete

1 B. A plan that proposes to terminate a health care
2 provider from the managed health care plan shall explain in
3 writing the rationale for its proposed termination and deliver
4 reasonable advance written notice to the provider prior to the
5 proposed effective date of the termination.

6 C. A managed health care plan shall adopt and
7 implement a process pursuant to which providers may raise with
8 the plan concerns that they may have regarding operation of the
9 plan, including concerns regarding quality of and access to
10 health care services, the choice of health care providers and the
11 adequacy of the plan's provider network. The process shall
12 include, at a minimum, the right of the provider to present the
13 provider's concerns to a plan committee responsible for the
14 substantive area addressed by the concern, and the assurance that
15 the concern will be conveyed to the plan's governing body. In
16 addition, a managed health care plan shall adopt and implement a
17 fair hearing plan that permits a health care provider to dispute
18 the existence of adequate cause to terminate the provider's
19 participation with the plan to the extent that the relationship
20 is terminated for cause and shall include in each provider
21 contract a dispute resolution mechanism."

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

24 "NEW MATERIAL] POINT-OF-SERVICE OPTION PLAN. --

25 A. Except as otherwise provided in this section, the
department may require a plan that offers a point-of-service plan
or open plan to include in any managed health care plan it offers
an option for a point-of-service plan or open plan to the extent

1 that the department determines that the open plan option is
2 financially sound.

3 B. No health care insurer may be required to offer a
4 point-of-service plan or open plan as an option under a medicaid-
5 funded managed health care plan unless the human services
6 department has established such a requirement as part of a
7 procurement for managed health care under the medicaid program. "

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

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

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

18 "[NEW MATERIAL] PRIVATE REMEDIES TO ENFORCE PATIENT AND
19 PROVIDER INSURANCE RIGHTS-- ENROLLEE AS THIRD-PARTY BENEFICIARY TO
20 ENFORCE RIGHTS. --

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

B. A person likely to be damaged by a denial of a
right protected pursuant to the provisions of the Patient
Protection Act or its regulations may be granted an injunction

1 under the principles of equity and on terms that the court
 2 considers reasonable. Proof of monetary damage or intent to
 3 violate a right is not required.

4 C. To protect and enforce an enrollee's rights in a
 5 managed health care plan, an individual enrollee participating in
 6 or eligible to participate in a managed health care plan shall be
 7 treated as a third-party beneficiary of the managed health care
 8 plan contract between the plan and the party with which the plan
 9 directly contracts. An individual enrollee may sue to enforce
 10 the rights provided in the contract that governs the managed
 11 health care plan; provided, however, that the plan and the party
 12 to the contract may amend the terms of, or terminate the
 13 provisions of, the contract without the enrollee's consent.

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

17 E. In any class action filed pursuant to this
 18 section, the court may award damages to the named plaintiffs as
 19 provided in this section and may award members of the class the
 20 actual damages suffered by each member of the class as a result
 21 of the unlawful practice.

22 F. Nothing in the Patient Protection Act is intended
 23 to make a plan vicariously liable for the actions of independent
 24 contractor health care providers. "

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

"[NEW MATERIAL] APPLICATION OF ACT TO MEDICAID PROGRAM --

A. Except as otherwise provided in this section, the

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1 provisions of the Patient Protection Act apply to the medicaid
2 program operation in the state. A managed health care plan
3 offered through the medicaid program shall grant enrollees and
4 providers the same rights and protections as are granted to
5 enrollees and providers in any other managed health care plan
6 subject to the provisions of the Patient Protection Act.

7 B. Nothing in the Patient Protection Act shall be
8 construed to limit the authority of the human services department
9 to administer the medicaid program, as required by law.

10 Consistent with applicable state and federal law, the human
11 services department shall have sole authority to determine,
12 establish and enforce medicaid eligibility criteria, the scope,
13 definitions and limitations of medicaid benefits and the minimum
14 qualifications or standards for medicaid service providers.

15 C. Medicaid recipients and applicants retain their
16 right to appeal decisions adversely affecting their medicaid
17 benefits to the human services department, pursuant to the Public
18 Assistance Appeals Act. Notwithstanding other provisions of the
19 Patient Protection Act, a medicaid recipient or applicant who
20 files an appeal to the human services department pursuant to the
21 Public Assistance Appeals Act may not file an appeal on the same
22 issue to the superintendent pursuant to the Patient Protection
23 Act, unless the human services department refuses to hear the
24 appeal. The superintendent may refer to the human services
25 department any appeal filed with the superintendent pursuant to
the Patient Protection Act if the complainant is a medicaid
beneficiary and the matter in dispute is subject to the
provisions of the Public Assistance Appeals Act.

1 D. Any managed health care plan participating in the
 2 medicaid managed care program as of the effective date of the
 3 Patient Protection Act and that is in compliance with contractual
 4 and regulatory requirements applicable to that program shall be
 5 deemed to comply with any requirements established in accordance
 6 with that act until July 1, 1999; provided that, from the
 7 effective date of that act, any rights established under that act
 8 beyond those under requirements of the human services department
 9 shall apply to enrollees in medicaid managed health care plans. "

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

12 "[NEW MATERIAL] PENALTY. --In addition to any other
 13 penalties provided by law, a civil administrative penalty of up
 14 to ten thousand dollars (\$10,000) may be imposed for each
 15 violation of the Patient Protection Act. An administrative
 16 penalty shall be imposed by written order of the superintendent
 17 made after holding a hearing as provided for in Chapter 59A,
 18 Article 4 NMSA 1978. "

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

21 "59A-1-16. EXEMPTED FROM CODE. --In addition to
 22 organizations and businesses otherwise exempt, the Insurance Code
 23 shall not apply [~~as~~] to:

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

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

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

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

15 "59A-46-30. STATUTORY CONSTRUCTION AND RELATIONSHIP TO
16 OTHER LAWS. --

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

(1) Chapter 59A, Article 1 NMSA 1978;

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

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

C. Any health maintenance organization authorized

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1 under the provisions of the Health Maintenance Organization Law
2 shall not be deemed to be practicing medicine and shall be exempt
3 from the provisions of laws relating to the practice of
4 medicine. "

5 Section 14. Section 59A-47-33 NMSA 1978 (being Laws 1984,
6 Chapter 127, Section 879.32, as amended by Laws 1997, Chapter 7,
7 Section 4 and by Laws 1997, Chapter 248, Section 3 and also by
8 Laws 1997, Chapter 255, Section 4) is amended to read:

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

- 20 A. Chapter 59A, Article 1 NMSA 1978;
- 21 B. Chapter 59A, Article 2 NMSA 1978;
- 22 C. Chapter 59A, Article 4 NMSA 1978;
- 23 D. Subsection C of Section 59A-5-22 NMSA 1978;
- 24 E. Sections 59A-6-2 through 59A-6-4 and
25 59A-6-6 NMSA 1978;
- F. Section 59A-7-11 NMSA 1978;
- G. Chapter 59A, Article 8 NMSA 1978;
- H. Chapter 59A, Article 10 NMSA 1978;

- I. Section 59A-12-22 NMSA 1978;
- J. Chapter 59A, Article 16 NMSA 1978;
- K. Chapter 59A, Article 18 NMSA 1978;
- L. Chapter 59A, Article 19 NMSA 1978;
- M. Subsections B through E of Section 59A-22-5 NMSA 1978;

N. Section 59A-22-14 NMSA 1978;

~~[N.]~~ O. Section 59A-22-34.1 NMSA 1978;

~~[O.]~~ P. Section 59A-22-39 NMSA 1978;

~~[P.]~~ Q. Section 59A-22-40 NMSA 1978;

~~[Q.]~~ R. Section 59A-22-41 NMSA 1978;

~~[R.]~~ S. Sections 59A-34-9 through 59A-34-13 and 59A-34-23 NMSA 1978;

~~[S.]~~ T. Chapter 59A, Article 37 NMSA 1978, except Section 59A-37-7 NMSA 1978; [~~and~~]

~~[T.]~~ U. Section 59A-46-15 NMSA 1978; and

V. the Patient Protection Act. "

Section 15. EFFECTIVE DATE. -- The effective date of the provisions of this act is July 1, 1998.

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1 HOUSE BUSINESS AND ~~INDUSTRY~~ ^{HOUSE BILL 361} COMMITTEE SUBSTITUTE FOR
2 43RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 1998
3
4
5
6
7
8

9 AN ACT

10 RELATING TO INSURANCE; ENACTING THE PATIENT PROTECTION ACT;
11 PROVIDING PROTECTIONS FOR PERSONS IN MANAGED HEALTH CARE
12 PLANS; APPLYING PATIENT PROTECTIONS TO MEDICAID MANAGED CARE;
13 IMPOSING A CIVIL PENALTY; AMENDING AND ENACTING SECTIONS OF
14 THE NMSA 1978.

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

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

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

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

22 "[NEW MATERIAL] PURPOSE OF ACT. -- The purpose of the
23 Patient Protection Act is to regulate aspects of health
24 insurance by specifying patient and provider rights and
25 confirming and clarifying the authority of the department to
adopt regulations to provide protections to persons enrolled

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in managed health care plans. The insurance protections should ensure that managed health care plans treat patients fairly and arrange for the delivery of good quality services."

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

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

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

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

C. "department" means the insurance department;

D. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

E. "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;

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14 offered by the plan, physical health or community-based mental
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22 or employed by the health care insurer or provider service
23 network. "Managed health care plan" or "plan" does not include a
24 health care insurer or provider service network offering a
25 traditional fee-for-service indemnity benefit or a benefit that
covers only short-term travel, accident-only, limited benefit,
student health plan or specified disease policies;

K. "person" means an individual or other legal

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2 L. "point-of-service plan" or "open plan" means a
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4 providers other than providers under direct contract with or
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3 ensure that each covered person enrolled in a plan is treated
4 fairly and in accordance with the requirements of the Patient
5 Protection Act. In adopting regulations to implement the
6 provisions of Subparagraphs (a) and (b) of Paragraph (3) and
7 Paragraphs (5) and (6) of Subsection B of this section regarding
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9 programs and continuous quality improvement programs, the
10 department shall cooperate with and seek advice from the
11 department of health.

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25 persons;

(2) a managed health care plan shall provide
health care services that are reasonably accessible and available
in a timely manner to each covered person;

1 (3) in providing reasonably accessible health
2 care services that are available in a timely manner, a managed
3 health care plan shall ensure that:

4 (a) the plan offers sufficient numbers and
5 types of qualified and adequately staffed health care providers
6 at reasonable hours of service to provide health care services to
7 the plan's enrollees;

8 (b) health care providers that are
9 specialists may act as primary care providers for patients with
10 chronic medical conditions, provided the specialists offer all
11 basic health care services that are required of them by a managed
12 health care plan;

13 (c) reasonable access is provided to
14 out-of-network health care providers if medically necessary
15 covered services are not reasonably available through
16 participating health care providers or if necessary to provide
17 continuity of care during brief transition periods;

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

22 (e) the plan, through provider selection,
23 provider education, the provision of additional resources or
24 other means, reasonably addresses the cultural and linguistic
25 diversity of its enrollee population;

(4) a managed health care plan shall adopt and
implement a prompt and fair grievance procedure for resolving
patient complaints and addressing patient questions and concerns

1 regarding any aspect of the plan, including the quality of and
2 access to health care, the choice of health care provider or
3 treatment and the adequacy of the plan's provider network. The
4 grievance procedure shall notify patients of their right to
5 obtain review by the plan, their right to obtain review by the
6 superintendent, their right to expedited review of emergent
7 utilization decisions and their rights under the Patient
8 Protection Act;

9 (5) a managed health care plan shall adopt and
10 implement a comprehensive utilization review program. The basis
11 of a decision to deny care shall be disclosed to an affected
12 enrollee. The decision to approve or deny care to an enrollee
13 shall be made in a timely manner, and the final decision shall be
14 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 procedure
19 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:

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

Underscored material = new
[bracketed material] = delete

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

7 B. Each managed health care plan shall establish a
 8 consumer advisory board. The board shall meet at least quarterly
 9 and shall advise the plan about the plan's general operations
 10 from the perspective of the enrollee as a consumer of health
 11 care. The board shall also review the operations of and be
 12 advisory to the plan's consumer assistance office.

13 C. The department shall establish and adequately
 14 staff a managed care ombudsman office, either within the
 15 department or by contract. The purpose of the managed care
 16 ombudsman office shall be to assist patients in exercising their
 17 rights and help advocate for and protect patient interests. The
 18 department's managed care ombudsman office shall work in
 19 conjunction with each plan's consumer assistance office and shall
 20 independently evaluate the effectiveness of the plan's consumer
 21 assistance office. The department's managed care ombudsman
 22 office may require a plan's consumer assistance office to adopt
 23 measures to ensure that the plan operates effectively to protect
 24 patient rights and inform consumers of the information to which
 25 they are entitled.

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

Underscored material = new
 [bracketed material] = delete

1 complaints.

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

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

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

18 A. No managed health care plan may:

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

22 (2) include in any of its contracts with health
23 care providers any provisions that offer an inducement, financial
24 or otherwise, to provide less than medically necessary services
25 to an enrollee; or

(3) require a health care provider to violate
any recognized fiduciary duty of his profession or place his
license in jeopardy.

1 B. A plan that proposes to terminate a health care
2 provider from the managed health care plan shall explain in
3 writing the rationale for its proposed termination and deliver
4 reasonable advance written notice to the provider prior to the
5 proposed effective date of the termination.

6 C. A managed health care plan shall adopt and
7 implement a process pursuant to which providers may raise with
8 the plan concerns that they may have regarding operation of the
9 plan, including concerns regarding quality of and access to
10 health care services, the choice of health care providers and the
11 adequacy of the plan's provider network. The process shall
12 include, at a minimum, the right of the provider to present the
13 provider's concerns to a plan committee responsible for the
14 substantive area addressed by the concern, and the assurance that
15 the concern will be conveyed to the plan's governing body. In
16 addition, a managed health care plan shall adopt and implement a
17 fair hearing plan that permits a health care provider to dispute
18 the existence of adequate cause to terminate the provider's
19 participation with the plan to the extent that the relationship
20 is terminated for cause and shall include in each provider
21 contract a dispute resolution mechanism."

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

24 "NEW MATERIAL] POINT-OF-SERVICE OPTION PLAN. --

25 A. Except as otherwise provided in this section, the
department may require a plan that offers a point-of-service plan
or open plan to include in any managed health care plan it offers
an option for a point-of-service plan or open plan to the extent

1 that the department determines that the open plan option is
2 financially sound.

3 B. No health care insurer may be required to offer a
4 point-of-service plan or open plan as an option under a medicaid-
5 funded managed health care plan unless the human services
6 department has established such a requirement as part of a
7 procurement for managed health care under the medicaid program."

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

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

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

18 "[NEW MATERIAL] PRIVATE REMEDIES TO ENFORCE PATIENT AND
19 PROVIDER INSURANCE RIGHTS--ENROLLEE AS THIRD-PARTY BENEFICIARY TO
20 ENFORCE RIGHTS. --

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

B. A person likely to be damaged by a denial of a
right protected pursuant to the provisions of the Patient
Protection Act or its regulations may be granted an injunction

1 under the principles of equity and on terms that the court
 2 considers reasonable. Proof of monetary damage or intent to
 3 violate a right is not required.

4 C. To protect and enforce an enrollee's rights in a
 5 managed health care plan, an individual enrollee participating in
 6 or eligible to participate in a managed health care plan shall be
 7 treated as a third-party beneficiary of the managed health care
 8 plan contract between the plan and the party with which the plan
 9 directly contracts. An individual enrollee may sue to enforce
 10 the rights provided in the contract that governs the managed
 11 health care plan; provided, however, that the plan and the party
 12 to the contract may amend the terms of, or terminate the
 13 provisions of, the contract without the enrollee's consent.

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

17 E. In any class action filed pursuant to this
 18 section, the court may award damages to the named plaintiffs as
 19 provided in this section and may award members of the class the
 20 actual damages suffered by each member of the class as a result
 21 of the unlawful practice.

22 F. Nothing in the Patient Protection Act is intended
 23 to make a plan vicariously liable for the actions of independent
 24 contractor health care providers. "

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

"[NEW MATERIAL] APPLICATION OF ACT TO MEDICAID PROGRAM --

A. Except as otherwise provided in this section, the

Underscored material = new
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1 provisions of the Patient Protection Act apply to the medicaid
2 program operation in the state. A managed health care plan
3 offered through the medicaid program shall grant enrollees and
4 providers the same rights and protections as are granted to
5 enrollees and providers in any other managed health care plan
6 subject to the provisions of the Patient Protection Act.

7 B. Nothing in the Patient Protection Act shall be
8 construed to limit the authority of the human services department
9 to administer the medicaid program, as required by law.

10 Consistent with applicable state and federal law, the human
11 services department shall have sole authority to determine,
12 establish and enforce medicaid eligibility criteria, the scope,
13 definitions and limitations of medicaid benefits and the minimum
14 qualifications or standards for medicaid service providers.

15 C. Medicaid recipients and applicants retain their
16 right to appeal decisions adversely affecting their medicaid
17 benefits to the human services department, pursuant to the Public
18 Assistance Appeals Act. Notwithstanding other provisions of the
19 Patient Protection Act, a medicaid recipient or applicant who
20 files an appeal to the human services department pursuant to the
21 Public Assistance Appeals Act may not file an appeal on the same
22 issue to the superintendent pursuant to the Patient Protection
23 Act, unless the human services department refuses to hear the
24 appeal. The superintendent may refer to the human services
25 department any appeal filed with the superintendent pursuant to
the Patient Protection Act if the complainant is a medicaid
beneficiary and the matter in dispute is subject to the
provisions of the Public Assistance Appeals Act.

1 D. Any managed health care plan participating in the
2 medicaid managed care program as of the effective date of the
3 Patient Protection Act and that is in compliance with contractual
4 and regulatory requirements applicable to that program shall be
5 deemed to comply with any requirements established in accordance
6 with that act until July 1, 1999; provided that, from the
7 effective date of that act, any rights established under that act
8 beyond those under requirements of the human services department
9 shall apply to enrollees in medicaid managed health care plans. "

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

12 "[NEW MATERIAL] PENALTY. --In addition to any other
13 penalties provided by law, a civil administrative penalty of up
14 to ten thousand dollars (\$10,000) may be imposed for each
15 violation of the Patient Protection Act. An administrative
16 penalty shall be imposed by written order of the superintendent
17 made after holding a hearing as provided for in Chapter 59A,
18 Article 4 NMSA 1978. "

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

21 "59A-1-16. EXEMPTED FROM CODE. --In addition to
22 organizations and businesses otherwise exempt, the Insurance Code
23 shall not apply [~~as~~] to:

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

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

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

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

15 "59A-46-30. STATUTORY CONSTRUCTION AND RELATIONSHIP TO
16 OTHER LAWS. --

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

(1) Chapter 59A, Article 1 NMSA 1978;

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

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

C. Any health maintenance organization authorized

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1 under the provisions of the Health Maintenance Organization Law
2 shall not be deemed to be practicing medicine and shall be exempt
3 from the provisions of laws relating to the practice of
4 medicine. "

5 Section 14. Section 59A-47-33 NMSA 1978 (being Laws 1984,
6 Chapter 127, Section 879.32, as amended by Laws 1997, Chapter 7,
7 Section 4 and by Laws 1997, Chapter 248, Section 3 and also by
8 Laws 1997, Chapter 255, Section 4) is amended to read:

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

- 20 A. Chapter 59A, Article 1 NMSA 1978;
- 21 B. Chapter 59A, Article 2 NMSA 1978;
- 22 C. Chapter 59A, Article 4 NMSA 1978;
- 23 D. Subsection C of Section 59A-5-22 NMSA 1978;
- 24 E. Sections 59A-6-2 through 59A-6-4 and
25 59A-6-6 NMSA 1978;
- F. Section 59A-7-11 NMSA 1978;
- G. Chapter 59A, Article 8 NMSA 1978;
- H. Chapter 59A, Article 10 NMSA 1978;

- I. Section 59A-12-22 NMSA 1978;
- J. Chapter 59A, Article 16 NMSA 1978;
- K. Chapter 59A, Article 18 NMSA 1978;
- L. Chapter 59A, Article 19 NMSA 1978;
- M. Subsections B through E of Section 59A-22-5 NMSA 1978;

N. Section 59A-22-14 NMSA 1978;

~~[N.]~~ O. Section 59A-22-34.1 NMSA 1978;

~~[O.]~~ P. Section 59A-22-39 NMSA 1978;

~~[P.]~~ Q. Section 59A-22-40 NMSA 1978;

~~[Q.]~~ R. Section 59A-22-41 NMSA 1978;

~~[R.]~~ S. Sections 59A-34-9 through 59A-34-13 and 59A-34-23 NMSA 1978;

~~[S.]~~ T. Chapter 59A, Article 37 NMSA 1978, except Section 59A-37-7 NMSA 1978; [~~and~~]

~~[T.]~~ U. Section 59A-46-15 NMSA 1978; and

V. the Patient Protection Act. "

Section 15. EFFECTIVE DATE. -- The effective date of the provisions of this act is July 1, 1998.

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HBIC/HB 361

**FORTY-THIRD LEGISLATURE
SECOND SESSION, 1998**

February 13, 1998

Mr. Speaker:

Your APPROPRIATIONS AND FINANCE COMMITTEE, to whom
has been referred

HOUSE BUSINESS AND INDUSTRY COMMITTEE SUBSTITUTE FOR
HOUSE BILL 361

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

Respectfully submitted,

Max Coll, Chairman

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1 FORTY-THIRD LEGISLATURE
2 SECOND SESSION, 1998

3 Page 61

4
5 Adopted _____ Not Adopted _____
6 (Chief Clerk) (Chief Clerk)

7
8 Date _____

9
10 The roll call vote was 9 For 3 Against

11 Yes: 9

12 No: Bird, Buffett, Pearce

13 Excused: Coll, Knowles, Marquardt, Picraux, Vigil, Watchman

14 Absent: None

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FORTY-THIRD LEGISLATURE
SECOND SESSION, 1998

February 15, 1998

Mr. President:

Your CORPORATIONS & TRANSPORTATION COMMITTEE, to
whom has been referred

HOUSE BUSINESS AND INDUSTRY COMMITTEE SUBSTITUTE FOR
HOUSE BILL 361

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

Respectfully submitted,

Roman M. Maes, III, Chairman

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FORTY-THIRD LEGISLATURE
SECOND SESSION, 1998

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

Date _____

The roll call vote was 6 For 0 Against

Yes: 6

No: 0

Excused: Fidel, Kidd, McKibben, Robinson

Absent: None

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