

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

HOUSE BILL 26

44TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SPECIAL SESSION, 1999

INTRODUCED BY

Edward C. Sandoval

AN ACT

RELATING TO HEALTH; MAKING CHANGES IN THE PATIENT PROTECTION ACT; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

Section 1. Section 59A-57-1 NMSA 1978 (being Laws 1998, Chapter 107, Section 1) is amended to read:

"59A-57-1. SHORT TITLE. -- [~~Sections 1 through 11 of this act~~] Chapter 59A, Article 57 NMSA 1978 may be cited as the "Patient Protection Act". "

Section 2. Section 59A-57-2 NMSA 1978 (being Laws 1998, Chapter 107, Section 2) is amended to read:

"59A-57-2. PURPOSE OF ACT. -- The purpose of the Patient Protection Act is to regulate certain aspects of health insurance by specifying patient and provider rights, [~~and~~] confirming and clarifying the authority of the [~~department~~]

underscored material = new
[bracketed material] = delete

underscored material = new
[bracketed material] = delete

1 division to adopt regulations to provide [~~protections to~~
2 protection of persons enrolled in [~~managed health care~~] plans
3 [~~The insurance protections should ensure~~] and ensuring that
4 [~~managed health care~~] plans treat patients fairly and arrange
5 for the delivery of good quality services."

6 Section 3. Section 59A-57-3 NMSA 1978 (being Laws 1998,
7 Chapter 107, Section 3) is amended to read:

8 "59A-57-3. DEFINITIONS. -- As used in the Patient
9 Protection Act:

10 A. "clean claim" means a manually or
11 electronically submitted claim that contains all the required
12 data elements necessary for accurate determination without the
13 need for additional information from outside of the plan's
14 system and that contains no material deficiency or
15 impropriety, including lack of substantiating documentation
16 currently required by the plan or particular or unusual
17 circumstances requiring special treatment that prevents timely
18 payment from being made by the plan;

19 [A.] B. "continuous quality improvement" means an
20 ongoing and systematic effort to measure, evaluate and improve
21 a [~~managed health care~~] plan's process in order to improve
22 continually the quality of health care services provided to
23 enrollees;

24 [B. ~~"covered person", "enrollee", "patient" or~~
25 ~~"consumer" means an individual who is entitled to receive~~

underscored material = new
[bracketed material] = delete

1 ~~health care benefits provided by a managed health care plan;~~

2 C. ~~"department" means the insurance department;~~

3 ~~D.]~~ C. "emergency care" means health care
4 procedures, treatments or services delivered to [~~a covered~~
5 ~~person~~] an enrollee after the sudden onset of what reasonably
6 appears to be a medical condition that manifests itself by
7 symptoms of sufficient severity, including severe pain, that
8 the absence of immediate medical attention could be reasonably
9 expected by a reasonable layperson to result in jeopardy to a
10 person's health, serious impairment of bodily functions,
11 serious dysfunction of a bodily organ or part or disfigurement
12 to a person;

13 D. "enrollee" means a person who is entitled to
14 health care benefits pursuant to a plan;

15 E. "health care facility" means an institution
16 [~~providing~~] that is licensed or otherwise authorized by the
17 state to provide health care services [~~including a hospital or~~
18 ~~other licensed inpatient center; an ambulatory surgical or~~
19 ~~treatment center; a skilled nursing center; a residential~~
20 ~~treatment center;~~] and includes a home health agency [~~a~~
21 ~~diagnostic, laboratory or imaging center; and a rehabilitation~~
22 ~~or other therapeutic health setting;~~

23 F. ~~"health care insurer" means a person that has a~~
24 ~~valid certificate of authority in good standing under the~~
25 ~~Insurance Code to act as an insurer, health maintenance~~

underscored material = new
[bracketed material] = delete

1 ~~organization, nonprofit health care plan or prepaid dental~~
2 ~~plan];~~

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

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

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

17 ~~[J.]~~ ~~"managed health care plan" or "plan" means a~~
18 ~~health care insurer or a provider service network when~~
19 ~~offering a benefit that either requires a covered person to~~
20 ~~use, or creates incentives, including financial incentives,~~
21 ~~for a covered person to use, health care providers managed,~~
22 ~~owned, under contract with or employed by the health care~~
23 ~~insurer or provider service network. "Managed health care~~
24 ~~plan" or "plan" does not include a health care insurer or~~
25 ~~provider service network offering a traditional~~

underscored material = new
[bracketed material] = delete

1 ~~fee-for-service indemnity benefit or a benefit that covers~~
2 ~~only short-term travel, accident-only, limited benefit,~~
3 ~~student health plan or specified disease policies;~~

4 ~~K. "person" means an individual or other legal~~
5 ~~entity;]~~

6 I. "insurer" means a person that has a valid
7 certificate of authority in good standing under the Insurance
8 Code to act as an insurer, managed care organization, provider
9 service network, plan or prepaid dental plan;

10 J. "plan" means an insurer or a provider service
11 network when offering a benefit that either requires an
12 enrollee to use, or creates incentives, including financial
13 incentives, for an enrollee to use health care providers
14 managed, owned, under contract with or employed by the insurer
15 or provider service network. "Plan" does not include an
16 insurer or provider service network offering a traditional
17 fee-for-service indemnity benefit or a benefit that covers
18 only short-term travel, accident-only, limited benefit,
19 student health plan or specified disease policies;

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

underscored material = new
[bracketed material] = delete

1 providers;

2 [M-] L. "provider service network" means two or
3 more health care providers affiliated for the purpose of
4 providing health care services to covered persons on a
5 capitated or similar prepaid flat-rate basis that hold a
6 certificate of authority pursuant to the Provider Service
7 Network Act;

8 [N. ~~"superintendent" means the superintendent of~~
9 ~~insurance;~~] and

10 [O-] M. "utilization review" means a system for
11 reviewing the appropriate and efficient allocation of health
12 care services given or proposed to be given to a patient or
13 group of patients. "

14 Section 4. Section 59A-57-4 NMSA 1978 (being Laws 1998,
15 Chapter 107, Section 4) is amended to read:

16 "59A-57-4. [PATIENT] ENROLLEE RIGHTS--DISCLOSURES--
17 RIGHTS TO BASIC AND COMPREHENSIVE HEALTH CARE
18 SERVICES--GRIEVANCE PROCEDURE-- UTILIZATION REVIEW PROGRAM--
19 CONTINUOUS QUALITY PROGRAM --

20 A. [Each covered person enrolled in a managed
21 health care plan] An enrollee has the right to be treated
22 fairly. A [managed health care] plan shall arrange for the
23 delivery of good quality and appropriate health care services
24 to enrollees as defined in the particular subscriber
25 agreement. The [department] division shall adopt

underscored material = new
[bracketed material] = delete

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

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

16 (1) prior to or at the time of enrollment and
17 periodically thereafter as appropriate, a [~~managed health~~
18 ~~care~~] plan shall provide [~~a summary of benefits and~~
19 ~~exclusions, premium information and a provider listing. Within~~
20 ~~a reasonable time after enrollment and at subsequent periodic~~
21 ~~times as appropriate, a managed health care plan shall provide~~
22 ~~written material that contains, in a clear, conspicuous and~~
23 ~~readily understandable form, a full and fair disclosure of the~~
24 ~~plan's benefits, limitations, exclusions, conditions of~~
25 ~~eligibility, prior authorization requirements, enrollee~~

underscored material = new
[bracketed material] = delete

1 ~~financial responsibility for payments, grievance procedures,~~
2 ~~appeal rights and the patients' rights generally available to~~
3 ~~all covered persons;]~~ to all enrollees either directly or, in
4 the case of a group policy, through their employer, a written
5 description of the plan that contains, in a clear, concise and
6 readily understandable form, a full and fair disclosure of:

7 (a) the plan's benefits and exclusions,
8 limitations, premium information, health care providers,
9 conditions of eligibility, prior authorization requirements,
10 enrollee financial responsibility for payments, grievance
11 procedures, appeal rights and customer service phone line
12 information;

13 (b) the plan's provisions for referrals
14 or authorizations for specialty care, behavioral health
15 services and hospital services;

16 (c) the plan's procedures, if any, for
17 changing health care providers; and

18 (d) a summary of enrollees' rights
19 established pursuant to the Patient Protection Act and rules
20 adopted pursuant to that act;

21 (2) upon request of an enrollee, a plan shall
22 provide information on the rules and provisions that are
23 directly related to an enrollee's health care, including
24 formularies, enrollees' and health care providers' referral
25 procedures and utilization review;

underscored material = new
[bracketed material] = delete

1 (3) if an enrollee is responsible for paying
2 any portion of a bill, an insurer or health care provider
3 shall provide the enrollee with a copy of an intelligible
4 bill, including the portion and amount paid by the plan, but
5 this requirement does not apply to a flat co-pay paid by the
6 enrollee at the time the service is required;

7 ~~[(2)]~~ (4) a ~~[managed health care]~~ plan shall
8 provide health care services that are reasonably accessible
9 and available in a timely manner to each ~~[covered person]~~
10 enrollee;

11 ~~[(3)]~~ (5) in providing reasonably accessible
12 health care services that are available in a timely manner, a
13 ~~[managed health care]~~ plan shall ensure that:

14 (a) the plan offers sufficient numbers
15 and types of qualified and adequately staffed health care
16 providers at reasonable hours of service to provide health
17 care services to ~~[the plan's]~~ enrollees;

18 (b) health care providers that are
19 specialists may act as primary care providers for ~~[patients]~~
20 enrollees with chronic medical conditions ~~[provided]~~ if the
21 specialists offer all basic health care services that are
22 required of them by a ~~[managed health care]~~ plan;

23 (c) reasonable access is provided to
24 out-of-network health care providers if medically necessary
25 covered services are not reasonably available through

underscored material = new
[bracketed material] = delete

1 participating health care providers or if necessary to provide
2 continuity of care during brief transition periods;

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

7 (e) reimbursement for emergency care or
8 ambulance service is not contingent upon time constraints of
9 less than seven days for notification by the enrollee to the
10 plan or any other entity that the care or services have been
11 used; and

12 [~~(e) the plan~~] (f) through provider
13 selection, provider education, the provision of additional
14 resources or other means, reasonably addresses the cultural
15 and linguistic diversity of its enrollee population;

16 [(4)] (6) a [~~managed health care~~] plan
17 [~~shall~~] adopt and implement a prompt and fair grievance
18 procedure for resolving [~~patient~~] enrollees' complaints and
19 addressing [~~patient~~] enrollees' questions and concerns
20 regarding any aspect of the plan, including the quality of and
21 access to health care, the choice of health care provider or
22 treatment and the adequacy of the plan's provider network.
23 The grievance procedure shall [~~notify patients~~] require
24 notification of enrollees of their right to obtain review by
25 the plan, their right to obtain review by the superintendent,

underscored material = new
[bracketed material] = delete

1 their right to expedited review of emergent utilization
2 decisions and their rights under the Patient Protection Act;
3 [~~(5)~~] (7) a [~~managed health care~~] plan
4 [~~shall~~] adopt and implement a comprehensive utilization review
5 program in which:

6 (a) the basis of a decision to deny
7 care shall be disclosed to an affected enrollee;

8 (b) the decision to approve or deny
9 care to an enrollee shall be made in a timely manner; and

10 (c) the final decision shall be made by
11 a qualified health care professional;

12 (8) a plan's utilization review program
13 [~~shall~~] ensure that enrollees have proper access to health
14 care services, including referrals to necessary specialists;

15 (9) a decision made in a plan's utilization
16 review program [~~shall~~] be subject to the plan's grievance
17 procedure and appeal to the superintendent; and

18 [~~(6)~~] (10) a managed health care plan [~~shall~~]
19 adopt and implement a continuous quality improvement program
20 that monitors the quality and appropriateness of the health
21 care services provided by the plan. "

22 Section 5. A new section of the Patient Protection Act,
23 Section 59A-57-4.1 NMSA 1978, is enacted to read:

24 "59A-57-4.1. [NEW MATERIAL] REPORTS OF DENIAL OF CARE--
25 SANCTIONS. --

. 129604. 1

underscored material = new
[bracketed material] = delete

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

A. The division shall file a report with the legislature annually that includes at a minimum:

- (1) a summary of the aggregate data regarding denial of care categorized by:
 - (a) access issues;
 - (b) benefit or claim limitations; and
 - (c) administrative issues;
- (2) a summary of the aggregate data regarding internal grievances and appeals; and
- (3) any need for additional statutory direction to achieve its duties and objectives.

B. The superintendent may hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978 to determine if a plan is denying care excessively or unjustly. The superintendent may issue an order against an insurer that he deems necessary or appropriate to protect consumers regarding the denial of care, including ordering the prompt delivery of appropriate care, impositions of sanctions or the taking of disciplinary action that may include fines or license revocation. "

Section 6. Section 59A-57-5 NMSA 1978 (being Laws 1998, Chapter 107, Section 5) is amended to read:

"59A-57-5. CONSUMER ASSISTANCE--CONSUMER ADVISORY BOARDS
[~~OMBUDSMAN OFFICE~~]- - REPORTS TO CONSUMERS-- DUTIES AND POWERS OF
DIVISION AND SUPERINTENDENT--SUPERINTENDENT' S ORDERS TO

underscored material = new
[bracketed material] = delete

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

PROTECT CONSUMERS. --

A. ~~[Each managed health care]~~ A plan shall establish and adequately staff a consumer assistance office. The purpose of the consumer assistance office is to respond to consumer questions and concerns and assist ~~[patients]~~ enrollees in exercising their rights and protecting their interests as consumers of health care.

B. ~~[Each managed health care]~~ A plan shall establish a consumer advisory board. The board shall meet at least quarterly and shall advise the plan about the plan's general operations from the perspective of the enrollee as a consumer of health care. The board shall also review the operations of and be advisory to the plan's consumer assistance office.

~~[D.]~~ C. The ~~[department]~~ division in conjunction with the commission shall:

(1) prepare an annual report assessing the operations of ~~[managed health care]~~ plans subject to the ~~[department's]~~ division's oversight, including information about consumer complaints;

(2) develop or use standardized, quantitative performance measurements of plans based on a five point rating scale;

(3) survey high-use health care consumers, purchasers and health care providers to assess the quality of

underscored material = new
[bracketed material] = delete

1 clinical and service-related aspects of health care arranged
2 for or provided by plans in accordance with measurements
3 developed pursuant to Paragraph (2) of this subsection: and
4 (4) develop or use, test, refine and produce
5 one or more plan performance grade cards to provide consumers
6 with accurate, reliable and timely comparisons of plans.

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

20 Section 7. Section 59A-57-6 NMSA 1978 (being Laws 1998,
21 Chapter 107, Section 6) is amended to read:

22 "59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES
23 PROHIBITED-- GRIEVANCE PROCEDURE FOR PROVIDERS. --

24 A. No ~~[managed health care]~~ plan may:

25 (1) adopt a gag rule or practice that

underscored material = new
[bracketed material] = delete

1 prohibits a health care provider from discussing a treatment
2 option with an enrollee even if the plan does not approve of
3 the option;

4 (2) include in [~~any of its contracts~~] a
5 contract with a health care [~~providers any provisions~~]
6 provider a provision that [~~offer~~] offers an inducement,
7 financial or otherwise, to provide less than medically
8 necessary services to an enrollee; or

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

12 B. No contract or element of a contract between an
13 insurer or plan and a health care provider shall include any
14 provision that has the effect of relieving either party of
15 liability for its actions or inactions.

16 C. A plan shall:

17 (1) provide in a timely manner the necessary
18 authorization or response to any inquiry by a health care
19 provider required to provide health care services; and

20 (2) reasonably exhaust available local
21 resources if requested by the enrollee or his designee for
22 providing necessary health care services.

23 [~~B.~~] D. A plan that proposes to terminate a health
24 care provider from the [~~managed health care~~] plan shall
25 explain in writing the rationale for its proposed termination

underscored material = new
[bracketed material] = delete

1 and deliver reasonable advance written notice to the provider
2 prior to the proposed effective date of the termination.

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

21 F. Nothing in this section prohibits a plan from
22 taking action against a health care provider if the plan has
23 evidence that the provider's actions are illegal, constitute
24 medical malpractice or are contrary to accepted medical
25 practices. "

underscored material = new
[bracketed material] = delete

1 Section 8. Section 59A-57-7 NMSA 1978 (being Laws 1998,
2 Chapter 107, Section 7) is amended to read:

3 "59A-57-7. POINT-OF-SERVICE OPTION PLAN. --

4 A. Except as otherwise provided in this section,
5 the [~~department~~] division may require a plan that offers a
6 point-of-service plan or open plan to include in [~~any managed~~
7 ~~health care~~] a plan it offers an option for a point-of-service
8 plan or open plan to the extent that the [~~department~~] division
9 determines that the point-of-service plan or the open plan
10 option is financially sound.

11 B. No [~~health care insurer~~] plan may be required
12 to offer a point-of-service plan or open plan as an option
13 under a medicaid-funded [~~managed health care~~] plan unless the
14 human services department has established such a requirement
15 as part of a procurement for managed health care under the
16 medicaid program."

17 Section 9. A new section of the Patient Protection Act,
18 Section 59A-57-7.1 NMSA 1978, is enacted to read:

19 "59A-57-7.1. [NEW MATERIAL] PENALTY FOR LATE PAYMENT FOR
20 SERVICES--NOTICE FOR CLAIMS RECEIVED--STANDARD FORMS. --

21 A. A contract entered into between a plan and a
22 participating health care provider shall provide that if the
23 plan fails to make payment to that provider within thirty days
24 after a clean claim has been submitted by the provider to the
25 plan, the plan shall be liable for the amount due and unpaid

underscored material = new
[bracketed material] = delete

1 plus interest on that amount at the rate of one and one-half
2 percent per month computed on a daily basis.

3 B. If a plan contests a claim of a participating
4 health care provider, that plan shall notify the participating
5 provider in writing within thirty days of receipt of the claim
6 with the specific reason why it is not liable for the claim or
7 request additional information necessary to determine
8 liability for the claim.

9 C. If a portion of the claim submitted to the plan
10 by the participating health care provider for payment is in
11 dispute, the plan shall pay the undisputed portion of that
12 claim in accordance with provisions of Subsection A of this
13 section.

14 D. By December 1, 2000, the division shall
15 promulgate rules to require plans to:

16 (1) provide timely notice to participating
17 health care providers of claims received, both for claims
18 received electronically and for claims submitted manually; and

19 (2) utilize standardized forms for all
20 claims, authorization and other official communication between
21 a participating health care provider and the plan regarding
22 payment for health care services."

23 Section 10. Section 59A-57-8 NMSA 1978 (being Laws 1998,
24 Chapter 107, Section 8) is amended to read:

25 "59A-57-8. ADMINISTRATIVE COSTS AND BENEFIT COSTS

underscored material = new
[bracketed material] = delete

1 DISCLOSURES. -- The [~~department~~] division shall adopt
2 [~~regulations~~] rules to ensure that both the administrative
3 costs and the direct costs of a plan providing health care
4 services [~~of each managed health care plan~~] are fully and
5 fairly disclosed to consumers in a uniform manner that allows
6 meaningful cost comparisons among plans. "

7 Section 11. Section 59A-57-9 NMSA 1978 (being Laws 1998,
8 Chapter 107, Section 9) is amended to read:

9 "59A-57-9. PRIVATE REMEDIES TO ENFORCE [~~PATIENT AND~~
10 ~~PROVIDER~~] INSURANCE RIGHTS-- ENROLLEE AS THIRD-PARTY
11 BENEFICIARY TO ENFORCE RIGHTS. --

12 A. A person who suffers a loss as a result of a
13 violation of a right protected pursuant to the provisions of
14 the Patient Protection Act, [~~its regulations~~] rules adopted
15 pursuant to its provisions or the provisions of a [~~managed~~
16 ~~health care~~] plan may bring an action to recover actual
17 damages or the sum of one hundred dollars (\$100), whichever is
18 greater.

19 B. A person likely to be damaged by a denial of a
20 right protected pursuant to the provisions of the Patient
21 Protection Act [~~or its regulations~~], rules adopted pursuant to
22 its provisions or the provisions of a plan may be granted [~~an~~
23 ~~injunction under the principles of equity and on terms that~~
24 ~~the court considers reasonable~~] injunctive relief. Proof of
25 monetary damage or intent to violate a right is not required

underscored material = new
[bracketed material] = delete

1 as a condition of obtaining injunctive relief.

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

13 D. ~~[The]~~ Relief provided pursuant to this section
14 is in addition to other remedies available against the same
15 conduct under the common law or other statutes of this state.

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

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

24 Section 12. Section 59A-57-10 NMSA 1978 (being Laws
25 1998, Chapter 107, Section 10) is amended to read:

. 129604. 1

1 "59A-57-10. APPLICATION OF ACT TO MEDICAID PROGRAM --

2 A. Except as otherwise provided in this section,
3 the provisions of the Patient Protection Act and rules adopted
4 pursuant to that act apply to the medicaid program operation
5 in the state. A [~~managed health care~~] plan offered through
6 the medicaid program shall grant enrollees and health care
7 providers the same rights and protections as are granted to
8 enrollees and providers in any other [~~managed health care~~]
9 plan subject to the provisions of the Patient Protection Act.

10 B. Nothing in the Patient Protection Act [~~shall be~~
11 ~~construed to limit~~] limits the authority of the human services
12 department to administer the medicaid program, as required by
13 law. Consistent with applicable state and federal law, the
14 human services department shall have sole authority to
15 determine, establish and enforce medicaid eligibility
16 criteria, the scope, definitions and limitations of medicaid
17 benefits and the minimum qualifications or standards for
18 medicaid service providers.

19 C. Medicaid recipients and applicants retain their
20 right to appeal decisions adversely affecting their medicaid
21 benefits to the human services department, pursuant to the
22 Public Assistance Appeals Act. [~~Notwithstanding other~~
23 ~~provisions of the Patient Protection Act, a medicaid recipient~~
24 ~~or applicant who files an appeal to the human services~~
25 ~~department pursuant to the Public Assistance Appeals Act may~~

underscored material = new
[bracketed material] = delete

1 ~~not file an appeal on the same issue to the superintendent~~
2 ~~pursuant to the Patient Protection Act, unless the human~~
3 ~~services department refuses to hear the appeal.]~~ The
4 superintendent may refer to the human services department
5 [any] an appeal filed with the superintendent pursuant to the
6 Patient Protection Act if the complainant is a medicaid
7 beneficiary and the matter in dispute is subject to the
8 provisions of the Public Assistance Appeals Act.

9 D. Any [~~managed health care~~] plan participating in
10 the medicaid managed care program as of [~~the effective date of~~
11 ~~the Patient Protection Act~~] July 1, 1998 and that is in
12 compliance with contractual and regulatory requirements
13 applicable to that program shall be deemed to comply with any
14 requirements established in accordance with [~~that~~] the Patient
15 Protection Act until [July 1, 1999 provided that, from the
16 effective date of that act any rights established under that
17 act beyond those under requirements of the human services
18 department shall apply to enrollees in medicaid managed health
19 care plans] July 1, 2000. Effective July 1, 2000, the rules
20 promulgated by the department to implement the Patient
21 Protection Act shall apply to medicaid managed care plans
22 except when and to the extent such rules are in conflict with
23 rules or conditions imposed on the state or on such plans by
24 the federal government. "

25 Section 13. Section 59A-57-11 NMSA 1978 (being Laws

. 129604. 1

underscored material = new
[bracketed material] = del etc

1 1998, Chapter 107, Section 11) is amended to read:

2 "59A-57-11. PENALTY. --In addition to any other penalties
3 provided by law, a civil administrative penalty of up to ten
4 thousand dollars (\$10,000) may be imposed for each violation
5 by a plan of a prohibitive provision or a mandatory
6 requirement of the Patient Protection Act. An administrative
7 penalty shall be imposed by written order of the
8 superintendent made after holding a hearing as provided for in
9 Chapter 59A, Article 4 NMSA 1978. "

10 Section 14. A new section of the Patient Protection Act,
11 Section 59A-57-12 NMSA 1978, is enacted to read:

12 "59A-57-12. [NEW MATERIAL] CONFIDENTIALITY. --Nothing in
13 the Patient Protection Act requires disclosure of information
14 that is otherwise privileged or confidential under any other
15 provision of law. "

16 Section 15. EFFECTIVE DATE. --The effective date of the
17 provisions of this act is July 1, 2000.