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AN ACT
RELATING TO INSURANCE; ENACTING NEW SECTIONS OF THE HEALTH
CARE PURCHASING ACT AND THE SHORT-TERM HEALTH PLAN AND
EXCEPTED BENEFIT ACT TO ADDRESS ISSUES RELATED TO THE PRIOR
AUTHORIZATION PROCESS, COLLECTION OF OVERPAYMENTS, ACCEPTABLE
METHODS OF PAYMENT AND NETWORK LEASING.

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

SECTION 1. A new section of the Health Care Purchasing
Act is enacted to read:

"DENTAL COVERAGE--PRIOR AUTHORIZATION.--

A. For purposes of this section, "prior
authorization" means a written communication indicating
whether a specific service is covered or multiple services
are covered and reimbursable at a specific amount, subject to
applicable coinsurance and deductibles, and issued in
response to a request submitted by a provider using a format
prescribed by a dental plan.

B. Group coverage, including any form of
self-insurance, offered, issued or renewed under the Health
Care Purchasing Act that offers a dental plan shall provide a
prior authorization upon the submission of a properly
formatted request from the insured.

C. Group coverage, including any form of
self-insurance, offered, issued or renewed under the Health

1 Care Purchasing Act that offers a dental plan shall not deny
2 any claim subsequently submitted for services included in a
3 prior authorization unless one of the following circumstances
4 applies for each service denied:

5 (1) benefit limitations, including annual
6 maximums or frequency limitations, not applicable at the time
7 of the prior authorization, are reached due to the insured's
8 utilization subsequent to issuance of the prior
9 authorization;

10 (2) the documentation submitted for the
11 claim clearly fails to support the claim as originally
12 authorized;

13 (3) subsequent to the issuance of a prior
14 authorization, new services are provided to the insured or a
15 change in the insured's condition occurs that would cause
16 prior-authorized services to no longer be medically
17 necessary, based on prevailing standards of care;

18 (4) subsequent to the issuance of a prior
19 authorization, new services are provided to the insured or a
20 change in the insured's condition occurs such that the
21 prior-authorized procedure would at that time require
22 disapproval pursuant to the terms and conditions for coverage
23 under the insured's plan in effect at the time the request
24 for prior authorizations was made; or

25 (5) denial of the claim was due to one of

1 the following reasons:

2 (a) another entity is responsible for
3 payment;

4 (b) the provider has already been paid
5 for the services identified on the claim;

6 (c) the claim submitted was fraudulent;

7 (d) the prior authorization was based
8 on erroneous information provided to the dental plan by the
9 provider, the insured or other person; or

10 (e) the insured was not eligible for
11 the service on the date it was provided and the provider did
12 not know, or with the exercise of reasonable care, could not
13 have known the insured's eligibility status."

14 SECTION 2. A new section of the Health Care Purchasing
15 Act is enacted to read:

16 "DENTAL COVERAGE--DESIGNATION OF PAYMENT.--

17 A. Group coverage, including any form of
18 self-insurance, offered, issued or renewed under the Health
19 Care Purchasing Act that offers a dental plan shall provide
20 for the direct payment of covered benefits to a provider,
21 specified by the insured, regardless of the provider's
22 network or contractual status with the dental plan.

23 B. A dental plan shall provide for the direct
24 payment of covered benefits to a provider, specified by the
25 insured, by including on its claim forms an:

1 (1) option for the designation of payment
2 from the insured to the provider; and

3 (2) an attestation to be completed by the
4 insured."

5 SECTION 3. A new section of the Health Care Purchasing
6 Act is enacted to read:

7 "DENTAL COVERAGE--ERRONEOUSLY PAID CLAIMS--RESTRICTIONS
8 ON RECOVERY.--

9 A. Group coverage, including any form of
10 self-insurance, offered, issued or renewed under the Health
11 Care Purchasing Act that offers a dental plan shall establish
12 policies and procedures for payment recovery, including
13 providing:

14 (1) notice to the provider that identifies
15 the error made in the processing or payment of the claim;

16 (2) an explanation of the recovery being
17 sought; and

18 (3) an opportunity for the provider to
19 appeal the recovery being sought as set forth in Subsection C
20 of this section.

21 B. Group coverage, including any form of
22 self-insurance, offered, issued or renewed under the Health
23 Care Purchasing Act that offers a dental plan shall not
24 initiate payment recovery procedures more than twenty-four
25 months after the original payment for a claim was made unless

1 the claim was fraudulent or intentionally misrepresented.

2 C. Group coverage, including any form of
3 self-insurance, offered, issued or renewed under the Health
4 Care Purchasing Act that offers a dental plan shall not
5 attempt to recover an erroneously paid claim by withholding
6 or reducing payment for a different claim unless the plan:

7 (1) notifies the provider, in writing,
8 within twelve months of the erroneously paid claim; and

9 (2) advises the provider that an automatic
10 deduction shall occur within forty-five days of receiving
11 notification unless the provider submits a written appeal to
12 the plan pursuant to the grievance rules prescribed by the
13 superintendent of insurance.

14 D. The provisions of this section shall not apply
15 to duplicate payments."

16 SECTION 4. A new section of the Health Care Purchasing
17 Act is enacted to read:

18 "DENTAL COVERAGE--METHODS OF PAYMENT.--

19 A. For purposes of this section, "credit card
20 payment" means a type of electronic funds transfer whereby:

21 (1) an insurer issues a single-use series of
22 numbers associated with the payment of services rendered by
23 the provider and chargeable to a predetermined amount; and

24 (2) the provider is responsible for
25 processing the payment by using a credit card terminal or

1 internet portal.

2 B. Group coverage, including any form of
3 self-insurance, offered, issued or renewed under the Health
4 Care Purchasing Act that offers a dental plan shall not place
5 restrictions on a provider regarding acceptable methods of
6 payment, including designating credit card payments as the
7 only acceptable form of payment.

8 C. When transmitting a payment to a provider using
9 an electronic funds transfer, other than one made through the
10 automated clearinghouse network, an insurer:

11 (1) shall not charge a fee to the provider
12 solely to transmit a payment without the provider's consent;

13 (2) shall notify the provider of any other
14 fees associated with transmitting a payment; and

15 (3) shall provide a provider with a fee-free
16 method of transmitting a payment and provide instructions for
17 utilizing the method."

18 SECTION 5. A new section of the Health Care Purchasing
19 Act is enacted to read:

20 "DENTAL COVERAGE--PROVIDER NETWORK LEASING.--

21 A. For purposes of this section:

22 (1) "contracting entity" means any person or
23 entity that enters into direct contracts with a provider for
24 the delivery of services in the ordinary course of business;

25 (2) "provider" means a person acting within

1 the scope of licensure to provide dental services or
2 supplies;

3 (3) "provider network contract" means a
4 contract between a contracting entity and a provider
5 specifying the rights and responsibilities of the contracting
6 entity and providing for the delivery of and payment for
7 services to the insured; and

8 (4) "third party" means a person or entity
9 that enters into a contract with a contracting entity or with
10 another third party to gain access to the services or
11 contractual discounts of a provider network contract.

12 B. At a time when a contract relevant to granting
13 access to a provider network to a third party is entered into
14 or renewed, or when there are material modifications made, a
15 contracting entity shall not require a provider to
16 participate in third-party access to the provider network
17 contract or contract directly with a third party that
18 acquired the provider network. If a provider opts out, the
19 contracting entity shall not cancel or otherwise end a
20 contractual relationship with the provider. When initially
21 contracting with a provider, a contracting entity must accept
22 a qualified provider even if the provider rejects a network
23 lease provision.

24 C. A contracting entity shall not grant a third
25 party access to a provider network contract, a provider's

1 services or discounts provided pursuant to a provider network
2 contract unless:

3 (1) the provider network contract states
4 that the contracting entity may enter into an agreement with
5 a third party, allowing the third party to obtain the
6 insurer's rights and responsibilities as though the third
7 party were the contracting entity;

8 (2) the third party accessing the provider
9 network contract agrees to comply with all of the terms of
10 the provider network contract; and

11 (3) the contracting entity:

12 (a) identifies all third parties with
13 which it contracts in a list on its website that is updated
14 every ninety days;

15 (b) notifies a provider that a new
16 third party is planning to lease or purchase the provider
17 network contract, at least thirty business days before the
18 lease or purchase takes effect;

19 (c) requires the third party to
20 identify the source of the discount on all remittances or
21 explanation of benefits under which the discount is taken;
22 and

23 (d) makes available a copy of the
24 provider network contract relied upon in the adjudication of
25 a claim to a provider within thirty days of the provider's

1 request.

2 D. A third party's right to a provider's
3 discounted rate shall cease upon the termination date of the
4 provider network contract.

5 E. The provisions of this section shall not apply
6 if access to a provider network contract is granted to a
7 dental carrier of an entity operating in accordance with the
8 same brand licensee program as the contracting entity or to
9 an entity that is an affiliate of the contracting entity. A
10 list of the contracting entity's affiliates shall be made
11 available to a provider on the contracting entity's website."

12 SECTION 6. Section 59A-23G-1 NMSA 1978 (being
13 Laws 2019, Chapter 235, Section 1) is amended to read:

14 "59A-23G-1. SHORT TITLE.--Chapter 59A, Article 23G
15 NMSA 1978 may be cited as the "Short-Term Health Plan and
16 Excepted Benefit Act"."

17 SECTION 7. A new section of the Short-Term Health Plan
18 and Excepted Benefit Act is enacted to read:

19 "DENTAL PLAN--PRIOR AUTHORIZATION.--

20 A. For purposes of this section, "prior
21 authorization" means a written communication indicating
22 whether a specific service is covered or multiple services
23 are covered and reimbursable at a specific amount, subject to
24 applicable coinsurance and deductibles, and issued in
25 response to a request submitted by a provider using a format

1 prescribed by a dental plan.

2 B. A dental plan shall provide a prior
3 authorization upon the submission of a properly formatted
4 request from a covered person.

5 C. A dental plan shall not deny any claim
6 subsequently submitted for services included in a prior
7 authorization unless one of the following circumstances
8 applies for each service denied:

9 (1) benefit limitations, including annual
10 maximums or frequency limitations, not applicable at the time
11 of the prior authorization, are reached due to the covered
12 person's utilization subsequent to issuance of the prior
13 authorization;

14 (2) the documentation submitted for the
15 claim clearly fails to support the claim as originally
16 authorized;

17 (3) subsequent to the issuance of a prior
18 authorization, new services are provided to the covered
19 person or a change in the covered person's condition occurs
20 that would cause prior-authorized services to no longer be
21 medically necessary, based on prevailing standards of care;

22 (4) subsequent to the issuance of a prior
23 authorization, new services are provided to the covered
24 person or a change in the covered person's condition occurs
25 such that the prior-authorized procedure would at that time

1 require disapproval pursuant to the terms and conditions for
2 coverage under the covered person's plan in effect at the
3 time the request for prior authorization was made; or

4 (5) denial of the claim was due to one of
5 the following reasons:

6 (a) another entity is responsible for
7 payment;

8 (b) the provider has already been paid
9 for the services identified on the claim;

10 (c) the claim submitted was fraudulent;

11 (d) the prior authorization was based
12 on erroneous information provided to the dental plan by the
13 provider, the covered person or other person; or

14 (e) the covered person was not eligible
15 for the service on the date it was provided and the provider
16 did not know, or with the exercise of reasonable care, could
17 not have known the covered person's eligibility status."

18 SECTION 8. A new section of the Short-Term Health Plan
19 and Excepted Benefit Act is enacted to read:

20 "DENTAL PLAN--DESIGNATION OF PAYMENT.--

21 A. A dental plan shall provide for the direct
22 payment of covered benefits to a provider, specified by a
23 covered person, regardless of the provider's network or
24 contractual status with the dental plan.

25 B. A dental plan shall provide for the direct

1 payment of covered benefits to a provider, specified by a
2 covered person, by including on its claim forms an:

3 (1) option for the designation of payment
4 from the covered person to the provider; and

5 (2) an attestation to be completed by the
6 covered person."

7 SECTION 9. A new section of the Short-Term Health Plan
8 and Excepted Benefit Act is enacted to read:

9 "DENTAL PLAN--ERRONEOUSLY PAID CLAIMS--RESTRICTIONS ON
10 RECOVERY.--

11 A. A dental plan shall establish policies and
12 procedures for payment recovery, including providing:

13 (1) notice to the provider that identifies
14 the error made in the processing or payment of the claim;

15 (2) an explanation of the recovery being
16 sought; and

17 (3) an opportunity for the provider to
18 appeal the recovery being sought as set forth in Subsection C
19 of this section.

20 B. A dental plan shall not initiate payment
21 recovery procedures more than twenty-four months after the
22 original payment for a claim was made unless the claim was
23 fraudulent or intentionally misrepresented.

24 C. A dental plan shall not attempt to recover an
25 erroneously paid claim by withholding or reducing payment for

1 a different claim unless the plan:

2 (1) notifies the provider, in writing,
3 within twelve months of the erroneously paid claim; and

4 (2) advises the provider that an automatic
5 deduction shall occur within forty-five days of receiving
6 notification unless the provider submits a written appeal to
7 the plan pursuant to the grievance rules prescribed by the
8 superintendent of insurance.

9 D. The provisions of this section shall not apply
10 to duplicate payments."

11 SECTION 10. A new section of the Short-Term Health Plan
12 and Excepted Benefit Act is enacted to read:

13 "DENTAL PLAN--METHODS OF PAYMENT.--

14 A. For purposes of this section, "credit card
15 payment" means a type of electronic funds transfer whereby:

16 (1) a health insurance carrier issues a
17 single-use series of numbers associated with the payment of
18 services rendered by the provider and chargeable to a
19 predetermined amount; and

20 (2) the provider is responsible for
21 processing the payment by using a credit card terminal or
22 internet portal.

23 B. A health insurance carrier shall not place
24 restrictions on a provider regarding acceptable methods of
25 payment, including designating credit card payments as the

1 only acceptable form of payment.

2 C. When transmitting a payment to a provider using
3 an electronic funds transfer, other than one made through the
4 automated clearinghouse network, a health insurance carrier:

5 (1) shall not charge a fee to the provider
6 solely to transmit a payment without the provider's consent;

7 (2) shall notify the provider of any other
8 fees associated with transmitting a payment; and

9 (3) shall provide a provider with a fee-free
10 method of transmitting a payment and provide instructions for
11 utilizing the method."

12 SECTION 11. A new section of the Short-Term Health Plan
13 and Excepted Benefit Act is enacted to read:

14 "DENTAL PLAN--PROVIDER NETWORK LEASING.--

15 A. For purposes of this section:

16 (1) "contracting entity" means any person or
17 entity that enters into direct contracts with a provider for
18 the delivery of services in the ordinary course of business;

19 (2) "provider" means a person acting within
20 the scope of licensure to provide dental services or
21 supplies;

22 (3) "provider network contract" means a
23 contract between a contracting entity and a provider
24 specifying the rights and responsibilities of the contracting
25 entity and providing for the delivery of and payment for

1 services to covered persons; and

2 (4) "third party" means a person or entity
3 that enters into a contract with a contracting entity or with
4 another third party to gain access to the services or
5 contractual discounts of a provider network contract.

6 B. At a time when a contract relevant to granting
7 access to a provider network to a third party is entered into
8 or renewed, or when there are material modifications made, a
9 contracting entity shall not require a provider to
10 participate in third-party access to the provider network
11 contract or contract directly with a third party that
12 acquired the provider network. If a provider opts out, the
13 contracting entity shall not cancel or otherwise end a
14 contractual relationship with the provider. When initially
15 contracting with a provider, a contracting entity must accept
16 a qualified provider even if the provider rejects a network
17 lease provision.

18 C. A contracting entity shall not grant a third
19 party access to a provider network contract, a provider's
20 services or discounts provided pursuant to a provider network
21 contract unless:

22 (1) the provider network contract states
23 that the contracting entity may enter into an agreement with
24 a third party, allowing the third party to obtain the health
25 insurance carrier's rights and responsibilities as though the

1 third party were the contracting entity;

2 (2) the third party accessing the provider
3 network contract agrees to comply with all of the terms of
4 the provider network contract; and

5 (3) the contracting entity:

6 (a) identifies all third parties with
7 which it contracts in a list on its website that is updated
8 every ninety days;

9 (b) notifies a provider that a new
10 third party is planning to lease or purchase the provider
11 network contract at least thirty business days before the
12 lease or purchase takes effect;

13 (c) requires the third party to
14 identify the source of the discount on all remittances or
15 explanation of benefits under which the discount is taken;
16 and

17 (d) makes available a copy of the
18 provider network contract relied upon in the adjudication of
19 a claim to a provider within thirty days of the provider's
20 request.

21 D. A third party's right to a provider's
22 discounted rate shall cease upon the termination date of the
23 provider network contract.

24 E. The provisions of this section shall not apply
25 if access to a provider network contract is granted to a

1 dental carrier of an entity operating in accordance with the
2 same brand licensee program as the contracting entity or to
3 an entity that is an affiliate of the contracting entity. A
4 list of the contracting entity's affiliates shall be made
5 available to a provider on the contracting entity's website."

6 SECTION 12. APPLICABILITY.--The provisions of this act
7 apply to dental plans issued for delivery or renewed in this
8 state on or after January 1, 2024. _____

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