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HOUSE BILL 313

**53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017**

INTRODUCED BY

Deborah A. Armstrong and Elizabeth "Liz" Stefanics

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING THE SURPRISE BILLING  
PROTECTION ACT; PROVIDING FOR PROTECTION OF COVERED PERSONS  
FROM UNEXPECTED BILLING FROM PROVIDERS THAT DO NOT PARTICIPATE  
IN A HEALTH BENEFITS PLAN; PROVIDING FOR DISPUTE RESOLUTION;  
ESTABLISHING PENALTIES.

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.--This act may be cited as the  
"Surprise Billing Protection Act"."

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

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

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1           A. "ambulance service" means any government or  
2 transportation service designated and used or intended to be  
3 used for the transportation of sick or injured persons;

4           B. "balance billing" means the practice when a  
5 provider bills an insured for the difference between the  
6 provider's charge and the health carrier's allowed amount;

7           C. "claim" means a request from a provider for  
8 payment for health care services;

9           D. "coinsurance" means the percentage of the costs  
10 of a covered service that a covered person pays after the  
11 covered person pays the covered person's deductible;

12           E. "confidential proprietary information" means  
13 commercial or financial information:

14                   (1) that is privileged or confidential; and

15                   (2) the disclosure of which would cause  
16 substantial harm to the competitive position of the person that  
17 submitted the information;

18           F. "confidential record" means a record containing  
19 nonpublic personal health information, trade secrets or  
20 confidential proprietary information and copies thereof that  
21 are in the possession or control of the superintendent, any  
22 resolution organization or any other person that is produced  
23 by, obtained by or disclosed to any of these persons in the  
24 course of a dispute resolution process made pursuant to the  
25 Surprise Billing Protection Act;

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1           G. "copayment" means a fixed amount a covered  
2 person pays for a health care service either before or after  
3 the deductible is paid;

4           H. "cost-sharing" means a copayment, coinsurance,  
5 deductible or any other form of financial obligation of a  
6 covered person other than premium or share of premium, or any  
7 combination of any of these financial obligations as defined by  
8 the terms of the health care plan;

9           I. "covered benefits" means the specific health  
10 services provided under a health benefits plan;

11           J. "covered person" means an insured, policyholder,  
12 subscriber, enrollee or other individual participating in a  
13 health benefit plan, as a primary insured or as a dependent;

14           K. "covered service" means a health care service  
15 reimbursable by a health carrier pursuant to a health benefits  
16 plan;

17           L. "deductible" means a fixed dollar amount that a  
18 covered person may be required to pay during a benefit period  
19 before the health benefits plan begins payment for covered  
20 benefits; plans may have both individual and family deductibles  
21 and separate deductibles for specific services. Plans may  
22 offer first-dollar services without requiring a covered person  
23 to first meet the deductible;

24           M. "emergency medical condition" means a physical,  
25 mental or behavioral health condition that manifests itself by

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1 acute symptoms of sufficient severity, including severe pain  
2 that would lead a prudent layperson in that circumstance,  
3 possessing an average knowledge of medicine and health, to  
4 reasonably expect, in the absence of immediate medical  
5 attention, to result in:

6 (1) placing the individual's physical, mental  
7 or behavioral health or, with respect to a pregnant woman, the  
8 woman or her fetus's health in serious jeopardy;

9 (2) serious impairment of bodily function;

10 (3) serious impairment of any bodily organ or  
11 part;

12 (4) a condition described in other state or  
13 federal law, as applicable; or

14 (5) with respect to a pregnant woman who is  
15 having contractions, that:

16 (a) there is inadequate time to effect a  
17 safe transfer to another facility before delivery; or

18 (b) transfer to another facility may  
19 pose a threat to the health or safety of the woman or fetus;

20 N. "emergency services" means, with respect to an  
21 emergency medical condition:

22 (1) a medical or mental health screening  
23 examination that is within the capacity of the emergency  
24 department of a facility, including ancillary services  
25 routinely available to the emergency department to evaluate the

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1 emergency medical condition;

2 (2) any further medical or mental health  
3 examination and treatment to the extent that it is within the  
4 capabilities of the staff and facilities available at the  
5 hospital to stabilize the patient; and

6 (3) ambulance services used to transport an  
7 individual experiencing an emergency medical condition,  
8 including services provided by emergency medical technicians;

9 O. "facility" means an entity providing a health  
10 care service, including:

11 (1) a general, special, psychiatric or  
12 rehabilitation hospital;

13 (2) an ambulatory surgical center;

14 (3) a cancer treatment center;

15 (4) a birth center;

16 (5) an inpatient, outpatient or residential  
17 drug and alcohol treatment center;

18 (6) a laboratory, diagnostic or other  
19 outpatient medical service or testing center;

20 (7) a health care provider's office or clinic;

21 (8) an urgent care center; or

22 (9) any other therapeutic health care setting;

23 P. "health benefits plan" means a policy, contract,  
24 certificate or agreement entered into, offered or issued by a  
25 health carrier to provide, deliver, arrange for, pay for or

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1 reimburse any of the costs of health care services. For  
2 purposes of the Surprise Billing Protection Act, "health  
3 benefits plan" does not include any of the following:

- 4 (1) an accident-only policy;
- 5 (2) a credit-only policy;
- 6 (3) a long-term care or disability income  
7 policy;
- 8 (4) a specified disease policy;
- 9 (5) a medicare supplement policy;
- 10 (6) a federal TRICARE policy, including a  
11 federal civilian health and medical program of the uniformed  
12 services supplement policy;
- 13 (7) a fixed indemnity policy;
- 14 (8) a dental-only policy;
- 15 (9) a vision-only policy;
- 16 (10) a workers' compensation policy;
- 17 (11) an automobile medical payment policy; and
- 18 (12) any other policy specified in rules of  
19 the superintendent;

20 Q. "health care professional" means a physician or  
21 other health care practitioner, including a pharmacist, who is  
22 licensed, certified or otherwise authorized by this or another  
23 state to provide health care services in the regular course of  
24 business;

25 R. "health care service" means any service,

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1 supplies or procedure for the diagnosis, prevention, treatment,  
2 cure or relief of a health condition, illness, injury or  
3 disease and includes, to the extent offered by a health  
4 benefits plan, physical, behavioral and mental health services,  
5 including community-based mental health services and services  
6 for developmental disability or developmental delay;

7 S. "health carrier" means a person that has a valid  
8 certificate of authority in good standing issued pursuant to  
9 the Insurance Code to act as an insurer, including a health  
10 insurance company, fraternal benefit society, vision plan or  
11 pre-paid dental plan, a health maintenance organization, a  
12 hospital and health service corporation, a provider service  
13 network, a nonprofit health care plan, a third-party, or any  
14 other entity that contracts or offers to contract, or enters  
15 into agreements to provide, deliver, arrange for, pay for or  
16 reimburse any costs of health care services, or that provides,  
17 offers or administers health benefit plans and managed health  
18 care plans in this state;

19 T. "health information" means any information or  
20 data, except age or gender, whether oral or recorded in any  
21 form or medium, created by or derived from a health care  
22 provider, health care insurer or the consumer that relates to:

23 (1) the past, present or future physical,  
24 mental or behavioral health or condition of an individual;

25 (2) the provision of health care to an

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1 individual; or

2 (3) payment for the provision of health care  
3 to an individual;

4 U. "hospital" means a facility offering inpatient  
5 services, nursing and overnight care on a twenty-four-hour  
6 basis for diagnosing, treating and providing medical,  
7 psychological or surgical care for three or more separate  
8 individuals who have a physical or mental illness, disease,  
9 injury or a rehabilitative condition or are pregnant;

10 V. "inducement" means the act or process of  
11 enticing or persuading another person to take a certain course  
12 of action;

13 W. "network" means the group or groups of  
14 participating providers who have been contracted to provide  
15 services under a network plan or managed health care plan;

16 X. "network plan" means a health benefits plan that  
17 either requires a covered person to use, or creates incentives,  
18 including financial incentives, for a covered person to use  
19 providers and facilities managed, owned or under contract with  
20 or employed by the health carrier;

21 Y. "nonparticipating provider" means a provider who  
22 is not a participating provider; provided that as it relates to  
23 covered emergency services, a facility is a nonparticipating  
24 provider if the facility has not contracted with a health  
25 carrier to provide emergency services at a specified rate;



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1                   Z. "nonpublic personal health information" means:

2                   (1) health information that identifies the  
3 individual who is the subject of the information; or

4                   (2) health information about which there is a  
5 reasonable basis to believe could be used to identify an  
6 individual;

7                   AA. "participating provider" means a provider or  
8 facility who, under express contract with a health carrier or  
9 with its contractor or subcontractor, has agreed to provide  
10 health care services to covered persons with an expectation of  
11 receiving payment directly or indirectly from the health  
12 carrier, subject to copayments, coinsurance, deductibles or  
13 other cost-sharing provisions. The contract between the  
14 participating provider and the health carrier prohibits the  
15 participating provider from balance billing to covered persons;

16                   BB. "prior authorization" or "pre-certification"  
17 means a pre-service determination made by a health carrier  
18 regarding a covered person's eligibility for services, medical  
19 necessity, benefit coverage, location or appropriateness of  
20 services, pursuant to the terms of the health benefits plan;

21                   CC. "provider" means a licensed health care  
22 professional, hospital or other facility authorized to furnish  
23 health care services in this state;

24                   DD. "provider group" means two or more providers  
25 legally organized in a partnership, professional corporation or

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1 limited liability company formed to render health care  
2 services; a medical foundation; a not-for-profit corporation; a  
3 faculty practice plan; or other similar entity that satisfies  
4 one of the following criteria; provided that an entity that  
5 otherwise meets the definition of "provider group" pursuant to  
6 this subsection shall be considered a provider group although  
7 its shareholder, partners or owners of the provider group  
8 include single-provider professional corporations, limited  
9 liability companies formed to render professional services or  
10 other entities in which beneficial owners are individual  
11 providers:

12 (1) each provider that is a member of the  
13 group provides substantially the full range of services that  
14 any provider in the group routinely provides, including medical  
15 care, consultation, diagnosis or treatment, through the joint  
16 use of shared office space, facilities, equipment or personnel;

17 (2) substantially all of the services of the  
18 providers who are members of the group are provided through the  
19 group and are billed in the name of the group practice and  
20 amounts so received are treated as receipts of the group; and

21 (3) the overhead expenses of, and the income  
22 from, the group are distributed in accordance with methods  
23 previously determined by members of the group;

24 EE. "rebate" means a return of part of a payment  
25 service as a discount or reduction;

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1 FF. "record custodian" means the superintendent, a  
2 resolution organization assigned pursuant to Section 10 of the  
3 Surprise Billing Protection Act, or any other person who  
4 possesses or controls a confidential record;

5 GG. "resolution organization" means a qualified  
6 independent third-party claim dispute resolution;

7 HH. "stabilize" means to provide medical or mental  
8 health treatment of a condition as may be necessary to ensure,  
9 within reasonable medical probability, that no material  
10 deterioration of the condition is likely to result from or  
11 occur during the transfer of the individual from a facility or,  
12 with respect to an emergency medical condition, to deliver,  
13 including the delivery of a placenta;

14 II. "superintendent" means the superintendent of  
15 insurance or the office of superintendent of insurance; and

16 JJ. "trade secret" means information that is  
17 protected by the Uniform Trade Secrets Act or as otherwise  
18 provided by state and federal law."

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

21 "[NEW MATERIAL] SURPRISE BILL--DEFINED.--

22 A. A surprise bill for health care services is a  
23 bill for:

24 (1) an emergency medical, mental or behavioral  
25 health service or ambulance service provided to a covered

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1 person by a nonparticipating provider;

2 (2) services rendered by a nonparticipating  
3 provider at a participating facility, where a participating  
4 provider is unavailable or a nonparticipating provider renders  
5 unforeseen services, or unforeseen medical, mental or  
6 behavioral health services that arose at the time the health  
7 care services are rendered; or

8 (3) services rendered by a nonparticipating  
9 provider when the covered person was referred by a  
10 participating provider to a nonparticipating provider without  
11 the covered person's written acknowledgement that the  
12 participating provider is referring the covered person to a  
13 nonparticipating provider and that the referral may result in  
14 costs not covered by the health benefits plan.

15 B. "Surprise bill" does not mean a bill received  
16 for health care services when a participating provider is  
17 available and the covered person has elected to obtain services  
18 from a nonparticipating provider.

19 C. Nothing in this section shall be construed to  
20 prohibit a health carrier from appropriately utilizing  
21 reasonable medical management techniques."

22 SECTION 4. A new section of the New Mexico Insurance Code  
23 is enacted to read:

24 "[NEW MATERIAL] EMERGENCY SERVICES--COVERAGE.--

25 A. A health carrier shall:

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1 (1) cover those services necessary to screen  
2 and stabilize a covered person in a situation where a prudent  
3 layperson acting reasonably would believe that an emergency  
4 medical condition exists;

5 (2) cover emergency services necessary to  
6 screen and stabilize a covered person at a participating or  
7 nonparticipating hospital emergency department if a prudent  
8 layperson would reasonably believe that use of a participating  
9 hospital emergency department would result in a delay that  
10 would worsen the emergency, or if a provision of federal, state  
11 or local law requires the use of a specific provider or  
12 facility; and

13 (3) provide coverage for emergency services  
14 regardless of whether the services are furnished by a  
15 participating provider or nonparticipating provider.

16 B. A health carrier shall not require that prior  
17 authorization for emergency services be obtained by or on  
18 behalf of a covered person prior to the point of stabilization  
19 of that covered person if a prudent layperson acting reasonably  
20 would believe that an emergency medical condition or behavioral  
21 health condition exists.

22 C. A health carrier is solely liable for payment of  
23 fees to a nonparticipating provider of covered emergency  
24 services provided to a covered person as otherwise provided by  
25 law.

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1           D. A health carrier may impose a coinsurance,  
2 copayment or limitation of benefits requirement for a  
3 nonparticipating provider only to the same extent that the  
4 coinsurance, copayment or limitation of benefits requirement  
5 applies to a participating provider."

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

8           "[NEW MATERIAL] NON-EMERGENCY SERVICES COVERAGE.--

9           A. A health carrier is solely liable for payment of  
10 fees to a nonparticipating provider of covered non-emergency  
11 services provided to a covered person in accordance with the  
12 coverage terms of a health benefits plan, and a covered person  
13 shall not be liable for payment of fees to a nonparticipating  
14 provider, other than applicable copayments, coinsurance and  
15 deductibles, for covered non-emergency services that are  
16 provided:

17                   (1) in a facility that has a contract for the  
18 non-emergency services with the health carrier that the  
19 facility would be otherwise obligated to provide under contract  
20 with the health carrier;

21                   (2) when the covered person does not have the  
22 ability or opportunity to choose a participating provider who  
23 is available to treat the covered person; or

24                   (3) when medically necessary care is  
25 unavailable within a health benefits plan's network; provided

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1 that medical necessity shall be determined by a covered  
2 person's provider in conjunction with the covered person's  
3 health benefits plan.

4 B. Nothing in this subsection shall preclude a  
5 health carrier's use of reasonable medical management in  
6 providing benefits to a covered person."

7 SECTION 6. A new section of the New Mexico Insurance Code  
8 is enacted to read:

9 "[NEW MATERIAL] HOLD HARMLESS--COLLECTIONS REFERRALS--  
10 ASSIGNMENT OF BENEFITS--CREDIT AGAINST MAXIMUM OUT-OF-POCKET  
11 COST-SHARING AMOUNT.--

12 A. If a covered person receives a health care  
13 service from a nonparticipating provider, the nonparticipating  
14 provider shall not knowingly submit a surprise bill to the  
15 covered person for any amount in excess of the cost-sharing  
16 amounts that would have been imposed if the health care service  
17 had been rendered by a participating provider. The covered  
18 person's health carrier shall submit to the nonparticipating  
19 provider upon request a statement of the applicable in-network  
20 cost-sharing amounts owed by the covered person to the  
21 nonparticipating provider. The covered person shall be  
22 responsible for no more than the cost-sharing amounts that  
23 would have been due if the health care service had been  
24 rendered by a participating provider.

25 B. A nonparticipating provider shall not refer to

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1 collections a surprise bill.

2 C. A health benefits plan shall allow for  
3 assignment of benefits as outlined below:

4 (1) a nonparticipating provider of a health  
5 care service that does not knowingly submit a surprise bill to  
6 a covered person is deemed to have received an assignment of  
7 benefits from the covered person, and any reimbursement paid to  
8 the nonparticipating provider by the covered person's health  
9 benefits plan shall be paid directly to the nonparticipating  
10 provider. This provision waives any requirements for consent  
11 to assign benefits as otherwise provided pursuant to state law;  
12 and

13 (2) if a covered person receives a surprise  
14 bill, the covered person may submit a surprise bill complaint  
15 form to the covered person's health carrier in accordance with  
16 the provisions of Section 8 of the Surprise Billing Protection  
17 Act. Submission of the surprise bill complaint form to the  
18 health carrier shall effect an assignment of the covered  
19 person's benefits to the nonparticipating provider. Except in  
20 the case of insurance fraud, a health carrier shall hold  
21 harmless a covered person who submits a surprise bill complaint  
22 form to the covered person's health carrier against all but the  
23 in-network cost-sharing amount that would otherwise have been  
24 due.

25 D. A health carrier shall count toward a covered

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1 person's in-network deductible and maximum out-of-pocket  
2 cost-sharing amount each payment that a covered person makes to  
3 satisfy a surprise bill in accordance with the provisions of  
4 the Surprise Billing Protection Act."

5 SECTION 7. A new section of the New Mexico Insurance Code  
6 is enacted to read:

7 "[NEW MATERIAL] REBATES AND INDUCEMENTS--PROHIBITION.--A  
8 nonparticipating provider shall not, either directly or  
9 indirectly, knowingly waive, rebate, give, pay or offer to  
10 waive, rebate, give or pay all or part of a cost-sharing amount  
11 owed by a covered person pursuant to the terms of the covered  
12 person's health benefits plan as an inducement for the covered  
13 person to seek a health care service from that nonparticipating  
14 provider."

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

17 "[NEW MATERIAL] SURPRISE BILL COMPLAINT FORM--  
18 COMMUNICATION BY HOSPITALS--ADVANCE NOTIFICATION OF CHARGES FOR  
19 HEALTH CARE SERVICES.--

20 A. A surprise bill complaint form shall permit a  
21 covered person to declare the bill to be a surprise bill and to  
22 assign the covered person's benefits to the nonparticipating  
23 provider in accordance with the provisions of Subsection C of  
24 Section 6 of the Surprise Billing Protection Act.

25 B. When a covered person receives a health care

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1 service that may be subject to a surprise bill, each provider,  
2 facility and health carrier in any way associated with the  
3 service shall make a good-faith effort to apprise the covered  
4 person of the protections afforded pursuant to the Surprise  
5 Billing Protection Act and provide to the covered person a  
6 surprise bill complaint form and instructions for submitting it  
7 to the covered person's health carrier. In addition to  
8 providing information in the evidences of coverage, the health  
9 carrier shall explain the availability of the form on any  
10 explanation of benefits provided to the covered person.

11 C. By December 31, 2017:

12 (1) the superintendent shall adopt and  
13 promulgate rules to specify the content and format of a  
14 surprise bill complaint form that accords with the provisions  
15 of the Surprise Billing Protection Act. The superintendent  
16 shall make the complaint form available in a publicly  
17 accessible manner on the superintendent's website and in paper  
18 format upon request;

19 (2) a health carrier shall post on its website  
20 in a publicly accessible manner and in paper format upon  
21 request:

22 (a) the surprise bill complaint form  
23 established pursuant to the superintendent's rules; and

24 (b) language notifying covered persons  
25 of their rights pursuant to the Surprise Billing Protection Act

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1 with an explanation of benefits; and

2 (3) each hospital shall post in a publicly  
3 accessible manner on its website:

4 (a) the names and hyperlinks for direct  
5 access to the websites of all health benefits plans for which  
6 the hospital contracts as a network provider or participating  
7 provider;

8 (b) a statement that: 1) services may  
9 be provided in the hospital by participating providers as well  
10 as other providers who may separately bill the patient; 2)  
11 providers that provide health care services in the hospital may  
12 or may not participate with the same health benefits plans as  
13 the hospital; and 3) prospective patients should contact the  
14 provider that will provide services in that hospital to  
15 determine in which health benefits plan networks the provider  
16 participates as a network provider or preferred provider;

17 (c) the rights of covered persons under  
18 the Surprise Billing Protection Act; and

19 (d) information for the superintendent.

20 D. Any communication, including a bill, detailing  
21 the cost of a health care service covered by the Surprise  
22 Billing Protection Act shall clearly state that the covered  
23 person will only be responsible for payment of the applicable  
24 cost-sharing amounts under the covered person's health benefits  
25 plan.

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1           E. Prior to an admission, procedure or health care  
2 service and upon request by a covered person, a health carrier  
3 shall within five working days disclose either of the  
4 following:

5                   (1) the allowed amount of the admission,  
6 procedure or health care service, including any facility fees  
7 required, if the provider is in the covered person's health  
8 benefits plan network; or

9                   (2) amount that will be charged for the  
10 admission, procedure or service, including any facility fees  
11 required if the provider is outside of the covered person's  
12 health benefits policy network.

13           F. If a health carrier is unable to quote a  
14 specific amount as required in Subsection E of this section in  
15 advance due to the provider's inability to predict the specific  
16 treatment or diagnostic code, the health carrier shall do all  
17 of the following:

18                   (1) disclose the incomplete nature of the  
19 estimate;

20                   (2) inform the covered person of the  
21 provider's ability to obtain an updated estimate once  
22 additional information is obtained; and

23                   (3) disclose what is known concerning:

24                           (a) the estimated allowed amount for a  
25 proposed admission, procedure or health care service, including

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1 any facility fees required, if the provider is in the covered  
2 person's network; or

3 (b) the estimated amount that will be  
4 charged for a proposed admission, procedure or health care  
5 service, including any facility fees required, if the provider  
6 is outside of the covered person's network.

7 G. A health carrier may disclose information  
8 comparing the price for the required health care service at the  
9 selected hospital with other hospitals within the health  
10 carrier's health benefits plan network.

11 H. The requirements of this section do not apply to  
12 unscheduled health care services or health care services  
13 scheduled fewer than five days prior to the provision of the  
14 health care service."

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

17 "[NEW MATERIAL] OVERPAYMENT.--

18 A. If a covered person pays a nonparticipating  
19 provider more than the in-network cost-sharing amount, the  
20 nonparticipating provider shall refund to the covered person  
21 within one hundred business days of receipt any amount paid in  
22 excess of the in-network cost-sharing amount.

23 B. If a nonparticipating provider has not made a  
24 full refund of any amount paid in excess of the in-network  
25 cost-sharing amount to the covered person within thirty

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1 business days of receipt of the overpayment, interest shall  
2 accrue at the rate of ten percent per year beginning with the  
3 first calendar day after the thirty-business-day period.

4 C. The superintendent shall adopt and promulgate  
5 rules pursuant to this section."

6 SECTION 10. A new section of the New Mexico Insurance  
7 Code is enacted to read:

8 "[NEW MATERIAL] DIRECT DISPUTE RESOLUTION--PAYMENT FOR  
9 HEALTH CARE SERVICES.--

10 A. Nothing in the Surprise Billing Protection Act  
11 shall prevent a health carrier and a nonparticipating provider  
12 from mutually agreeing to a payment amount for a health care  
13 service outside of the mechanism set forth in this section, nor  
14 shall any provision of the Surprise Billing Protection Act be  
15 construed to prevent a health carrier from addressing the  
16 availability and use of participating providers in its  
17 contracts with in-network facilities and participating  
18 providers who make referrals to other providers.

19 B. If a health carrier receives a surprise bill  
20 complaint form and a bill from a covered person, or if a  
21 nonparticipating provider submits a bill for a health care  
22 service:

23 (1) the health carrier and nonparticipating  
24 provider may reach an agreement as to an amount to be paid for  
25 the nonparticipating provider's services, payment of which, in

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1 addition to the applicable in-network cost-sharing amount owed  
2 by the covered person, shall constitute payment in full to the  
3 nonparticipating provider for the health care service rendered;  
4 and

5 (2) the health carrier shall pay in accordance  
6 with the prompt pay requirements under state and federal law.

7 C. If a nonparticipating provider and a health  
8 carrier do not reach agreement on a payment amount through the  
9 negotiation process outlined in this section within forty-five  
10 calendar days after the health carrier received the bill for  
11 the health care service, either party may submit a formal  
12 dispute resolution request to the superintendent to include all  
13 claims pertaining to a covered person from a single episode of  
14 illness.

15 D. Calculation of the date of health carrier  
16 receipt of the bill shall align with prompt pay requirements  
17 under applicable state and federal law.

18 E. A health carrier's failure to respond within  
19 forty-five days to a nonparticipating provider's request for  
20 payment via a surprise bill complaint form shall constitute  
21 acceptance of the nonparticipating provider's charges. Payment  
22 of accepted charges shall align with prompt pay requirements  
23 pursuant to Section 59A-16-21.1 NMSA 1978."

24 **SECTION 11.** A new section of the New Mexico Insurance  
25 Code is enacted to read:

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1           "[NEW MATERIAL] INDEPENDENT DISPUTE RESOLUTION--COSTS.--

2           A. A health carrier or nonparticipating provider  
3 may initiate binding arbitration to determine reimbursement for  
4 health care services provided by a nonparticipating provider.  
5 Failure to respond within fifteen days to a nonparticipating  
6 provider's request for arbitration on a disputed payment shall  
7 constitute acceptance of the nonparticipating provider's  
8 charges. Payment of accepted charges shall align with prompt  
9 pay requirements pursuant to Section 59A-16-21.1 NMSA 1978.

10           B. Arbitration shall be initiated by filing a  
11 request with the superintendent. The parties may agree to  
12 resolve disputes over additional reimbursement for services for  
13 multiple covered lives or enrollees.

14           C. The superintendent shall publish a list of  
15 resolution organizations or arbitrators that provide binding  
16 arbitration.

17           D. Both parties must agree on an arbitrator from  
18 the list within five business days of submission of a request  
19 for arbitration.

20           E. If no agreement can be reached, a list of five  
21 arbitrators will be provided. From the list of five  
22 arbitrators, the party initiating arbitration shall first veto  
23 two arbitrators and then the other party shall veto two  
24 arbitrators from the remaining list. The remaining arbitrator  
25 shall be the chosen arbitrator.

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1           F. The party requesting arbitration shall notify  
2 the other party that arbitration has been initiated and state  
3 its final offer to resolve the dispute over reimbursement for  
4 services provided before arbitration occurs. In response to  
5 this notice, the non-requesting party shall inform the  
6 requesting party of its final offer before arbitration occurs.

7           G. The arbitrator's review shall consist of a  
8 review of both parties' final offers submitted to resolve the  
9 dispute over reimbursement for services. The arbitrator's  
10 decision may be one of the two amounts submitted by the parties  
11 as their final offers or another amount determined to be  
12 reasonable by the arbitrator. If the arbitrator finds that,  
13 given the final offers, a settlement between the health carrier  
14 and the nonparticipating provider is reasonably likely or that  
15 the final offers represent unreasonable extremes, the  
16 arbitrator may direct both parties to attempt a good-faith  
17 negotiation for settlement. The health carrier and  
18 nonparticipating provider may be granted up to ten days for  
19 this negotiation, which shall run concurrently with the  
20 thirty-day period for dispute resolution.

21           H. In making a determination pursuant to this  
22 section, the arbitrator may consider, and the parties shall  
23 provide at the resolution organization's request, documentation  
24 of the following:

25                   (1) the individual covered person's

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1 characteristics;

2 (2) the level of training, education and  
3 experience of the nonparticipating provider;

4 (3) the nonparticipating provider's usual  
5 charge for comparable services provided out-of-network with  
6 respect to any health benefits plans;

7 (4) the participating provider contracted rate  
8 of payment for comparable services;

9 (5) the usual and customary provider charges,  
10 as defined by a public independent database of charges, for the  
11 same or similar services in the same geographic area;

12 (6) the amount that would be paid under health  
13 coverage pursuant to health coverage under Part A or Part B of  
14 Title 18 of the federal Social Security Act, as amended, or  
15 federal-state medical assistance provided pursuant to Title 19  
16 or 21 of the federal Social Security Act for the service;

17 (7) the circumstances and complexity of the  
18 particular case, including the time and place of the service;

19 (8) the availability of the health care  
20 service for the covered person from participating providers;

21 (9) any payments made in prior surprise bill  
22 disputes between the provider and the health carrier; and

23 (10) the propensity of the provider to be  
24 included in health carrier networks.

25 I. The arbitrator shall issue a written decision

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1 within thirty days after assignment of the dispute for  
2 resolution. Copies of any written findings of fact shall be  
3 provided to both parties and the superintendent by the same  
4 means, whether electronic or hard copy.

5 J. The determination obtained through the  
6 resolution process pursuant to this section shall be binding on  
7 both parties and not appealable.

8 K. A final determination as to a claim code of a  
9 service shall be binding on the health carrier and the provider  
10 for any disputes between them involving the same claim code for  
11 a period of one year from the date of the determination.

12 L. The arbitrator's expenses and fees, together  
13 with other expenses, excluding attorney fees, incurred in the  
14 conduct of the arbitration shall be shared by the parties to  
15 the arbitration.

16 M. A party that fails to pay all amounts due to the  
17 other party and to the resolution organization within thirty  
18 days of receiving the final determination shall:

19 (1) pay interest to the resolution  
20 organization and to the prevailing party at one and one-half  
21 percent per month; and

22 (2) be subject to a penalty of one hundred  
23 dollars (\$100) per day, payable to the current school fund,  
24 until all payments are made in full.

25 N. Nothing in this section shall preclude the

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1 parties from reaching a resolution of their dispute before the  
2 arbitrator issues its decision.

3 O. A resolution organization shall:

4 (1) protect from disclosure, including in the  
5 information provided to the superintendent, any information  
6 specifically identifying the covered person who received the  
7 health care services that were the subject of an arbitration  
8 decision. The information shall be protected and remain  
9 confidential in compliance with all applicable federal and  
10 state laws and shall be confidential as a record pursuant to  
11 applicable state and federal law; and

12 (2) report to the superintendent any change in  
13 its status that would cause it to cease performing or being  
14 qualified to perform arbitrations pursuant to the Surprise  
15 Billing Protection Act."

16 SECTION 12. A new section of the New Mexico Insurance  
17 Code is enacted to read:

18 "[NEW MATERIAL] RECORDS--CONFIDENTIALITY--EXCEPTIONS--  
19 SUPERINTENDENT ANALYSIS--DISCLOSURE.--

20 A. A record custodian shall not disclose  
21 confidential information disclosed pursuant to the dispute  
22 resolution process established pursuant to the Surprise Billing  
23 Protection Act. A record containing confidential information  
24 is:

25 (1) confidential and privileged;

1 (2) not subject to the Inspection of Public  
2 Records Act;

3 (3) not subject to subpoena; and

4 (4) not subject to discovery or admissible as  
5 evidence in any private civil action.

6 B. A record custodian may disclose confidential  
7 information to the superintendent or resolution organization to  
8 facilitate the fulfillment of a duty or obligation under the  
9 Surprise Billing Protection Act. Any duty or obligation that  
10 requires the use of confidential information includes:

11 (1) arbitration of a disputed claim;

12 (2) resolution of a consumer complaint; and

13 (3) investigation of an alleged violation of  
14 the Surprise Billing Protection Act.

15 C. The provisions of this section do not prevent  
16 the superintendent from using confidential information for  
17 internal analysis or from disclosing aggregated confidential  
18 information in a way that the identity of the subject of the  
19 information cannot be ascertained.

20 D. The sharing of a record with, to or by the  
21 superintendent or resolution organization as authorized by the  
22 Surprise Billing Protection Act does not constitute a waiver of  
23 any applicable privilege or claim of confidentiality.

24 E. The rights to confidentiality conferred under  
25 this section do not create a private right of action."

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1           SECTION 13. A new section of the New Mexico Insurance  
2 Code is enacted to read:

3           "[NEW MATERIAL] ENFORCEMENT.--

4           A. The superintendent shall ensure compliance with  
5 the Surprise Billing Protection Act. The superintendent may  
6 investigate potential violations of that act based upon  
7 information received from covered persons, health carriers,  
8 providers and other sources in order to ensure compliance with  
9 the provisions of that act.

10           B. Upon satisfactory evidence of a violation of the  
11 Surprise Billing Protection Act by a health carrier, the  
12 superintendent may, at the superintendent's discretion, pursue  
13 any one of the following courses of action:

- 14                       (1) enter a cease and desist order;
- 15                       (2) impose a civil penalty of not more than  
16 five thousand dollars (\$5,000) for each action in violation of  
17 a provision of the Surprise Billing Protection Act. Any action  
18 taken to impose a civil penalty shall comply with applicable  
19 state and federal law;
- 20                       (3) impose a civil penalty of not more than  
21 ten thousand dollars (\$10,000) for each action in willful  
22 violation of a provision of the Surprise Billing Protection  
23 Act; or
- 24                       (4) impose any other penalty or remedy deemed  
25 appropriate by the superintendent, including restitution.

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1 C. Fines imposed against an individual health  
2 carrier under this section may not exceed three hundred  
3 thousand dollars (\$300,000) in the aggregate during a single  
4 calendar year.

5 D. The enforcement remedies under this section are  
6 in addition to any other remedies or penalties that may be  
7 imposed under any other applicable law."

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

10 "[NEW MATERIAL] PRIVATE CAUSE OF ACTION.--Nothing in the  
11 Surprise Billing Protection Act shall be construed to create or  
12 imply a private cause of action for a violation of that act."

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

15 "[NEW MATERIAL] RULEMAKING.--The superintendent shall  
16 promulgate rules as may be necessary to appropriate or  
17 implement the provisions of the Surprise Billing Protection  
18 Act."

19 SECTION 16. [NEW MATERIAL] SEVERABILITY.--If any part or  
20 application of the Surprise Billing Protection Act is held  
21 invalid, the remainder or its application to other situations  
22 or persons shall not be affected."

23 SECTION 17. APPLICABILITY.--The provisions of the  
24 Surprise Billing Protection Act apply to the following health  
25 coverage delivered or issued for delivery in this state:

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1           A. group health coverage governed by the provisions  
2 of the Health Care Purchasing Act;

3           B. individual health insurance policies, health  
4 care plans and certificates of insurance governed by the  
5 provisions of Chapter 59A, Article 22 NMSA 1978;

6           C. group and blanket health insurance policies,  
7 health care plans and certificates of insurance governed by the  
8 provisions of Chapter 59A, Article 23 NMSA 1978;

9           D. individual and group health maintenance  
10 organization plan contracts governed by the provisions of the  
11 Health Maintenance Organization Law; and

12           E. individual and group nonprofit health care plan  
13 contracts governed by the provisions of the Nonprofit Health  
14 Care Plan Law.

15           **SECTION 18. EFFECTIVE DATE.**--The effective date of the  
16 provisions of this act is October 1, 2017.