SENATE CORPORATIONS AND TRANSPORTATION COMMITTEE SUBSTITUTE FOR SENATE BILL 337

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

Pursuant to House Rule 24-1, this document incorporates amendments that have been adopted prior to consideration of this measure by the House. It is a tool to show the amendments in context and is not to be used for the purpose of amendments.

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 THE COVERED PERSON'S HEALTH BENEFITS PLAN; PROHIBITING SURPRISE BILLING AS AN UNFAIR PRACTICE; ESTABLISHING PENALTIES; PROVIDING FOR A CONTINGENT REPEAL.

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:

.214310.4

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = →bold, blue, highlight←
delete = →bold, red, highlight, strikethrough←

"[NEW MATERIAL] SHORT TITLE.--Sections 1 through 13 of 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:

A. "allowed amount" means the maximum portion of a billed charge that a health insurance carrier will pay, including any applicable covered person cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or by a nonparticipating provider;

B. "balance billing" means a nonparticipating provider's practice of issuing a bill to a covered person for the difference between the nonparticipating provider's billed charges on a claim and any amount paid by the health insurance carrier as reimbursement for that claim, excluding any cost-sharing amount due from the covered person;

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

D. "co-insurance" means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided that co-insurance rates may differ for different types of services

under the same health benefits plan;

E. "copayment" means a cost-sharing method that requires a covered person to pay a fixed dollar amount when health care services are received, with the health insurance carrier paying the balance allowable amount; provided that there may be different copayment requirements for different types of services under the same health benefits plan;

F. "cost sharing" means a copayment, co-insurance, deductible or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of a health benefits plan;

G. "covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan;

H. "covered person" means:

(1) an enrollee, policyholder or subscriber;

(2) the enrolled dependent of an enrollee, policyholder or subscriber; or

(3) another individual participating in a health benefits plan;

I. "deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits; provided that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services;

J. "emergency care" means a health care procedure,

treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person;

K. "facility" means an entity providing a health care service, including:

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

(2) an ambulatory surgical center;

(3) a cancer treatment center;

(4) a birth center;

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

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

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

(8) an urgent care center;

(9) a freestanding emergency room; or

(10) any other therapeutic health care setting;

L. "freestanding emergency room" means a facility licensed by the department of health that is separate from an acute care hospital and that provides twenty-four-hour emergency care to patients at the same level of care that a hospital-based emergency room delivers;

M. "health benefits plan" means a policy or agreement entered into or offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(1) an accident-only policy;

(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

(5) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(6) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act;

(7) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(8) a fixed or hospital indemnity policy;

(9) a dental-only policy;

(10) a vision-only policy;

(11) a workers' compensation policy;

(12) an automobile medical payment policy; or

(13) any other policy specified in rules of the superintendent;

N. "health care services":

(1) means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan; and

(2) does not mean ambulance transportation services;

O. "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services or that provides, offers or administers a health benefit policy or managed health care plan in the state;

P. "hospital" means a facility offering inpatient health care services, nursing care and overnight care for three or more individuals on a twenty-four-hours-per-day, seven-days-

per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions;

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

R. "network" means the group or groups of participating providers that have been contracted to provide health care services under a network plan;

S. "network plan" means a health benefits plan that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers and facilities managed, owned, under contract with or employed by the health insurance carrier offering the health benefits plan;

T. "nonparticipating provider" means a provider who is not a participating provider;

U. "participating provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing;

V. "prior authorization" means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for services, medical necessity, benefit coverage and the location or appropriateness of services, pursuant to the terms of a health benefits plan that

the health insurance carrier offers;

W. "provider" means a health care professional, hospital or other facility licensed to furnish health care services;

X. "stabilize" means to provide emergency care to a patient as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient to a facility or, with respect to emergency labor, to deliver, including the delivery of a placenta; and

Y. "surprise bill":

(1) means a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

(a) emergency care provided by the nonparticipating provider; or

(b) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where: 1) a participating provider is unavailable; 2) a nonparticipating provider renders unforeseen services; or 3) a nonparticipating provider renders services for which the covered person has not given specific consent for

that nonparticipating provider to render the particular services rendered; and

(2) does not mean a bill:

(a) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or

(b) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care HHHC→or for services rendered pursuant to Subparagraph (b) of Paragraph (1) of this subsection←HHHC."

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

"[NEW MATERIAL] EMERGENCY CARE--REIMBURSEMENT--LIMITATION ON CHARGES.--

A. A health insurance carrier shall reimburse a nonparticipating provider for emergency care necessary to evaluate and stabilize a covered person if a prudent layperson would reasonably believe that emergency care is necessary, regardless of eventual diagnosis.

B. A health insurance carrier shall not require that prior authorization for emergency care be obtained by, or on behalf of, a covered person prior to the point of stabilization of that covered person if a prudent layperson would reasonably believe that the covered person requires

emergency care.

C. A health insurance carrier may impose a cost-sharing or limitation of benefits requirement for emergency care performed by a nonparticipating provider only to the same extent that the copayment, co-insurance or limitation of benefits requirement applies for participating providers and is documented in the policy.

D. A health insurance carrier may require an emergency care provider to notify a health insurance carrier of a covered person's admission to the hospital within a reasonable time period after the covered person has been stabilized."

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

"[NEW MATERIAL] NON-EMERGENCY CARE--LIMITATION ON CHARGES.--

A. Other than applicable cost sharing that would apply if a participating provider had rendered the same services, a health insurance carrier shall provide reimbursement for and a covered person shall not be liable for charges and fees for covered non-emergency care rendered by a nonparticipating provider that are delivered when:

(1) the covered person at an in-network facility does not have the ability or opportunity to choose a participating provider who is available to provide the covered

services; or

(2) medically necessary care is unavailable within a health benefits plan's network; provided that "medical necessity" shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan and health insurance carrier.

B. Except as set forth in Subsection A of this section, nothing in this section shall preclude a nonparticipating provider from balance billing for non-emergency care provided by a nonparticipating provider to an individual who has knowingly chosen to receive services from that nonparticipating provider."

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

"[NEW MATERIAL] CREDIT AGAINST MAXIMUM OUT-OF-POCKET COST-SHARING AMOUNT--COMMUNICATION BY HOSPITALS--ADVANCE NOTIFICATION OF CHARGES FOR HEALTH CARE SERVICES.--

A. A nonparticipating provider shall not knowingly submit a surprise bill to a covered person.

B. In accordance with the hearing procedures established pursuant to the Patient Protection Act, a covered person may appeal a health insurance carrier's determination made regarding a surprise bill.

C. By July 1, 2020, the department of health shall require each health facility licensed pursuant to the Public Health Act to post the following on the health facility's website in a publicly accessible manner:

(1) the names and hyperlinks for direct access

to the websites of all health insurance carriers with which the hospital has a contract for services;

(2) a statement that sets forth the following:

(a) services may be performed in the hospital by participating providers as well as nonparticipating providers who may separately bill the patient;

(b) providers that perform health care services in the hospital may or may not participate in the same health benefits plans as the hospital; and

(c) prospective patients should contact their health insurance carriers in advance of receiving services at that hospital to determine whether the scheduled health care services provided in that hospital will be covered at in-network rates;

(3) the rights of covered persons under the Surprise Billing Protection Act; and

(4) instructions for contacting the superintendent.

D. Any written communication, other than a receipt of payment, from a provider or health insurance carrier pertaining to a surprise bill, shall clearly state that the covered person is responsible only for payment of applicable in-network cost-sharing amounts under the covered person's health benefits plan. A collection agency collecting medical debt from New Mexico residents shall post a notice of consumer

rights pursuant to the Surprise Billing Protection Act on its website.

E. When a nonparticipating provider under nonemergency circumstances has advance knowledge that the nonparticipating provider is not contracted with the covered person's health insurance carrier, the nonparticipating provider shall inform the covered person of the nonparticipating provider's nonparticipating status and advise the covered person to contact the covered person's health insurance carrier to discuss the covered person's options."

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

"[NEW MATERIAL] COVERED PERSONS--PROVIDERS--OVERPAYMENT.--

A. If a covered person pays a nonparticipating provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the nonparticipating provider shall refund to the covered person within forty-five calendar days of receipt of payment from the health insurance carrier any amount paid in excess of the in-network cost-sharing amount.

B. If a nonparticipating provider has not made a full refund to the covered person of any amount paid in excess of the in-network cost-sharing amount to the covered person within forty-five calendar days of receipt, interest shall accrue at the rate set for payment of interest on a health plan's liability for clean claims submitted by eligible providers to a health plan pursuant to Chapter 59A, Article 16 NMSA 1978.

C. A covered person may seek recovery of the refund of the amount the covered person has paid in excess of the in-network cost-sharing amount that a nonparticipating provider owes, plus interest, pursuant to Subsection B of this section by filing an appeal with the office of superintendent of insurance. The superintendent of insurance shall develop an appeals process pursuant to this section."

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

"[NEW MATERIAL] NONPARTICIPATING PROVIDERS--REBATES AND INDUCEMENTS--PROHIBITION.--A nonparticipating provider shall not, either directly or indirectly, knowingly waive, rebate, give, pay or offer to waive, rebate, give or pay all or part of a cost-sharing amount owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek a health care service from that nonparticipating provider. The superintendent may impose fines on providers for unlawful rebates and inducements; provided that a provider on which the superintendent intends to impose a fine shall be entitled to a hearing in accordance with the provisions of Section 59A-4-15 NMSA 1978."

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

"[NEW MATERIAL] HEALTH CARE PROVIDER REIMBURSEMENT RATES--SURPRISE BILLING.--

A. The superintendent shall convene appropriate stakeholders SJC→, including rural providers, insurers and consumer advocates,←SJC and review the reimbursement rate for surprise bills annually to ensure fairness to providers and to evaluate the impact on health insurance premiums and health benefits plan networks.

B. Calculation of the date of health insurance carrier receipt of a claim shall align with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978.

C. A health insurance carrier shall make available to providers access to claims status information."

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

"[NEW MATERIAL] REASONABLE HEALTH CARE COST MANAGEMENT PERMITTED.--Nothing in the Surprise Billing Protection Act shall be construed to prohibit a health insurance carrier from appropriately using reasonable health care cost management techniques."

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

"[NEW MATERIAL] PRIVATE CAUSE OF ACTION.--Except as provided in Subsection C of Section 6 of the Surprise Billing Protection Act, nothing in that act shall be construed to create or imply a private cause of action for a violation of that act."

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

"[NEW MATERIAL] SJC→~~RULEMAKING~~←SJC SJC→**INFORMATION FROM PROVIDER NETWORKS**←SJC.--The superintendent:

SJC→~~A. shall promulgate rules as may be necessary to appropriately implement the provisions of the Surprise Billing Protection Act; and~~←SJC

SJC→~~B.~~ **A.**←SJC may require SJC→~~by rule~~←SJC that health insurance carriers report the annual percentage of claims and expenditures paid to nonparticipating providers for health care services SJC→~~.~~"←SJC

SJC→**B. may require by rule a report on changes to the percent of claims paid as an emergency claim."**←SJC

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

"[NEW MATERIAL] APPLICABILITY.--The provisions of the Surprise Billing Protection Act apply to the following types of health coverage delivered or issued for delivery in this state:

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

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

C. multiple-employer welfare arrangements governed by the provisions of Section 59A-15-20 NMSA 1978;

D. group and blanket health insurance policies, health benefits plans and certificates of insurance governed by

the provisions of Chapter 59A, Article 23 NMSA 1978;

E. individual and group health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law; and

F. individual and group nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law."

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

"[NEW MATERIAL] PROVIDERS--REIMBURSEMENT FOR A SURPRISE BILL.--

A. For services provided pursuant to Section 3 or 4 of the Surprise Billing Protection Act, a health insurance carrier shall directly reimburse a nonparticipating provider for care rendered the surprise bill reimbursement rate for services.

B. The surprise bill reimbursement rate shall be calculated using claims data reflecting the allowed amounts paid for claims paid in the 2017 plan year.

C. As used in this section, "surprise bill reimbursement rate" means the sixtieth percentile of the allowed commercial reimbursement rate for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent after consultation with health care sector stakeholders SJC→**; provided that no surprise bill reimbursement rate shall be paid at less than one hundred fifty**

percent of the 2017 medicare reimbursement rate for the applicable health care service provided←SJC.

D. The nonprofit organization shall be conflict-free and unaffiliated with any stakeholder in the health care sector."

SECTION 14. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--SURPRISE BILLING PROHIBITED.--

A. A provider shall not knowingly submit to a covered person a surprise bill for health care services, which surprise bill demands payment for any amount in excess of the cost-sharing amounts that would have been imposed by the covered person's health benefits plan if the health care service from which the surprise bill arises had been rendered by a participating provider.

B. It shall be an unfair practice for a health care provider to knowingly submit a surprise bill to a collection agency.

C. As used in this section:

(1) "covered person" means:

(a) an enrollee, policyholder or subscriber;

(b) the enrolled dependent of an enrollee, policyholder or subscriber; or

(c) another individual participating in a health benefits plan;

(2) "emergency care" means a health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person;

(3) "facility" means an entity providing a health care service, including:

(a) a general, special, psychiatric or rehabilitation hospital;

(b) an ambulatory surgical center;

(c) a cancer treatment center;

(d) a birth center;

(e) an inpatient, outpatient or residential drug and alcohol treatment center;

(f) a laboratory, diagnostic or other outpatient medical service or testing center;

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

(h) an urgent care center;

(i) a freestanding emergency room; or

(j) any other therapeutic health care setting;

(4) "freestanding emergency room" means a facility licensed by the department of health that is separate from an acute care hospital and that provides twenty-four-hour emergency care to patients at the same level of care that a hospital-based emergency room delivers;

(5) "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(a) an accident-only policy;

(b) a credit-only policy;

(c) a long- or short-term care or disability income policy;

(d) a specified disease policy;

(e) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(f) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act;

(g) a federal TRICARE policy, including

a federal civilian health and medical program of the uniformed services supplement;

(h) a fixed or hospital indemnity policy;

(i) a dental-only policy;

(j) a vision-only policy;

(k) a workers' compensation policy;

(l) an automobile medical payment policy; or

(m) any other policy specified in rules of the superintendent;

(6) "health care services":

(a) means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan; and

(b) does not mean ambulance transportation services;

(7) "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services or that provides, offers or administers a health benefit policy or managed health care plan in the state;

(8) "hospital" means a facility offering inpatient health care services, nursing care and overnight care for three or more individuals on a twenty-four-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions;

(9) "nonparticipating provider" means a provider who is not a participating provider;

(10) "participating provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing;

(11) "prior authorization" means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for health care services, medical necessity, benefit coverage and the location or appropriateness of services, pursuant to the terms of a health benefits plan that the health insurance carrier offers;

(12) "provider" means a health care professional, hospital or other facility licensed to furnish health care services; and

(13) "surprise bill":

(a) means a bill that a nonparticipating

provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider: 1) emergency care provided by the nonparticipating provider; or 2) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where a: participating provider is unavailable; a nonparticipating provider renders unforeseen services; or a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered; and

(b) does not mean a bill: 1) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization; or 2) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care."

SECTION 15. DELAYED REPEAL.--Section 13 of this act is repealed effective July 1, 2023.

SECTION 16. EFFECTIVE DATE.--The effective date of the provisions of this act is January 1, 2020.

.214310.4