

1 SENATE BILL 337

2 **54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019**

3 INTRODUCED BY

4 Linda M. Lopez

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9  
10 AN ACT

11 RELATING TO HEALTH COVERAGE; ENACTING THE SURPRISE BILLING  
12 PROTECTION ACT; PROVIDING FOR PROTECTION OF COVERED PERSONS  
13 FROM UNEXPECTED BILLING FROM PROVIDERS THAT DO NOT PARTICIPATE  
14 IN THE COVERED PERSON'S HEALTH BENEFITS PLAN; PROHIBITING  
15 SURPRISE BILLING AS AN UNFAIR PRACTICE; ESTABLISHING PENALTIES;  
16 PROVIDING FOR A CONTINGENT REPEAL.

17  
18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

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

21 "[NEW MATERIAL] SHORT TITLE.--Sections 1 through 13 of  
22 this act may be cited as the "Surprise Billing Protection  
23 Act"."

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

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

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

9           B. "ambulance transportation service" means any  
10 government or private ground transportation service designated  
11 and used, or intended to be used, for the transportation of  
12 sick or injured persons;

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

19           D. "claim" means a request from a provider for  
20 payment for health care services rendered;

21           E. "co-insurance" means a cost-sharing method that  
22 requires a covered person to pay a stated percentage of medical  
23 expenses after any deductible amount is paid; provided that co-  
24 insurance rates may differ for different types of services  
25 under the same health benefits plan;

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

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

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

15           I. "covered person" means:

16                   (1) an enrollee, policyholder or subscriber;

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

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

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

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1 specific services;

2 K. "emergency care" means a health care procedure,  
3 treatment, service or ambulance transportation service  
4 delivered to a covered person after the sudden onset of what  
5 reasonably appears to be a medical or behavioral health  
6 condition that manifests itself by symptoms of sufficient  
7 severity, including severe pain, that the absence of immediate  
8 medical attention, regardless of eventual diagnosis, could be  
9 expected by a reasonable layperson to result in jeopardy to a  
10 person's physical or mental health or to the health or safety  
11 of a fetus or pregnant person, serious impairment of bodily  
12 function, serious dysfunction of a bodily organ or part or  
13 disfigurement to a person;

14 L. "facility" means an entity providing a health  
15 care service, including:

- 16 (1) a general, special, psychiatric or  
17 rehabilitation hospital;
- 18 (2) an ambulatory surgical center;
- 19 (3) a cancer treatment center;
- 20 (4) a birth center;
- 21 (5) an inpatient, outpatient or residential  
22 drug and alcohol treatment center;
- 23 (6) a laboratory, diagnostic or other  
24 outpatient medical service or testing center;
- 25 (7) a health care provider's office or clinic;

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- 1 (8) an urgent care center;  
2 (9) a freestanding emergency room; or  
3 (10) any other therapeutic health care  
4 setting;

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

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

- 16 (1) an accident-only policy;  
17 (2) a credit-only policy;  
18 (3) a long- or short-term care or disability  
19 income policy;  
20 (4) a specified disease policy;  
21 (5) coverage provided pursuant to Title 18 of  
22 the federal Social Security Act, as amended;  
23 (6) a federal TRICARE policy, including a  
24 federal civilian health and medical program of the uniformed  
25 services supplement;

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- 1 (7) a fixed indemnity policy;
- 2 (8) a dental-only policy;
- 3 (9) a vision-only policy;
- 4 (10) a workers' compensation policy;
- 5 (11) an automobile medical payment policy; or
- 6 (12) any other policy specified in rules of
- 7 the superintendent;

8 O. "health care services" means any service, supply  
9 or procedure for the diagnosis, prevention, treatment, cure or  
10 relief of a health condition, illness, injury or other disease,  
11 including physical or behavioral health services, to the extent  
12 offered by a health benefits plan;

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

22 Q. "hospital" means a facility offering inpatient  
23 health care services, nursing care and overnight care for three  
24 or more individuals on a twenty-four-hours-per-day, seven-days-  
25 per-week basis for the diagnosis and treatment of physical,

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1 behavioral or rehabilitative health conditions;

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

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

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

14 U. "nonparticipating provider" means a provider who  
15 is not a participating provider;

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

23 W. "prior authorization" means a pre-service  
24 determination made by a health insurance carrier regarding a  
25 covered person's eligibility for services, medical necessity,

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1 benefit coverage and the location or appropriateness of  
2 services, pursuant to the terms of a health benefits plan that  
3 the health insurance carrier offers;

4 X. "provider" means a health care professional,  
5 hospital or other facility licensed to furnish health care  
6 services;

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

13 Z. "surprise bill":

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

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

22 (b) health care services, that are not  
23 emergency care, rendered by a nonparticipating provider at a  
24 participating facility where: 1) a participating provider is  
25 unavailable; 2) a nonparticipating provider renders unforeseen



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1 services; or 3) a nonparticipating provider renders services  
2 for which the covered person has not given specific consent for  
3 that nonparticipating provider to render the particular  
4 services rendered; and

5 (2) does not mean a bill:

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

11 (b) received for health care services  
12 rendered by a nonparticipating provider to a covered person  
13 whose coverage is provided pursuant to a preferred provider  
14 plan; provided that the health care services are not provided  
15 as emergency care."

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

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

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

25 B. A health insurance carrier shall not require

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1 that prior authorization for emergency care be obtained by, or  
2 on behalf of, a covered person prior to the point of  
3 stabilization of that covered person if a prudent layperson  
4 would reasonably believe that the covered person requires  
5 emergency care.

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

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

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

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

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

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1 nonparticipating provider that are delivered when:

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

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

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

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

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

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

24 B. In accordance with the hearing procedures  
25 established pursuant to the Patient Protection Act, a covered

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1 person may appeal a health insurance carrier's determination  
2 made regarding a surprise bill.

3 C. By December 31, 2019, the department of health  
4 shall require each health facility licensed pursuant to the  
5 Public Health Act to post the following on the health  
6 facility's website in a publicly accessible manner:

7 (1) the names and hyperlinks for direct access  
8 to the websites of all health benefits plans for which the  
9 hospital has a contract for services;

10 (2) a statement that sets forth the following:

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

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

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

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

24 (4) instructions for contacting the  
25 superintendent.

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1           D. Any communication from a provider, bill  
2 collector or health insurance carrier pertaining to services  
3 provided under circumstances giving rise to a surprise bill  
4 shall clearly state that the covered person is responsible only  
5 for payment of applicable in-network cost-sharing amounts under  
6 the covered person's health benefits plan.

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

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

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

18           A. If a covered person pays a nonparticipating  
19 provider more than the in-network cost-sharing amount for  
20 services provided under circumstances giving rise to a surprise  
21 bill, the nonparticipating provider shall refund to the covered  
22 person within forty-five calendar days of receipt any amount  
23 paid in excess of the in-network cost-sharing amount.

24           B. If a nonparticipating provider has not made a  
25 full refund to the covered person of any amount paid in excess

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1 of the in-network cost-sharing amount to the covered person  
2 within forty-five calendar days of receipt, interest shall  
3 accrue at the rate of ten percent per year beginning with the  
4 first calendar day following the forty-five-calendar-day  
5 period.

6 C. A covered person may seek recovery of the refund  
7 of the amount the covered person has paid in excess of the in-  
8 network cost-sharing amount that a nonparticipating provider  
9 owes, plus interest, pursuant to Subsection B of this section  
10 by bringing an action in district court to recover that  
11 overpayment amount and interest owed and reasonable costs and  
12 attorney fees, if approved by the court."

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

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

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1 the provisions of Section 59A-4-15 NMSA 1978."

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

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

6 A. The superintendent shall review the  
7 reimbursement rate for surprise bills by July 1, 2022 and every  
8 three years thereafter to ensure fairness to providers and to  
9 evaluate the impact on health insurance premiums.

10 B. Calculation of the date of health insurance  
11 carrier receipt of a claim shall align with requirements for  
12 prompt payment established pursuant to Section 59A-16-21.1 NMSA  
13 1978.

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

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

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

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

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

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

7 "[NEW MATERIAL] RULEMAKING.--The superintendent:

8 A. shall promulgate rules as may be necessary to  
9 appropriately implement the provisions of the Surprise Billing  
10 Protection Act; and

11 B. may require by rule that health insurance  
12 carriers report the annual percentage of claims and  
13 expenditures paid to nonparticipating providers for health care  
14 services."

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

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

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

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

25 C. multiple-employer welfare arrangements governed

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1 by the provisions of Section 59A-15-20 NMSA 1978;

2 D. group and blanket health insurance policies,  
3 health benefits plans and certificates of insurance governed by  
4 the provisions of Chapter 59A, Article 23 NMSA 1978;

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

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

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

13 "[NEW MATERIAL] PROVIDERS--REIMBURSEMENT FOR A SURPRISE  
14 BILL.--For services provided under circumstances giving rise to  
15 a surprise bill, a health insurance carrier shall directly  
16 reimburse a nonparticipating provider for care rendered the  
17 greatest of the following amounts:

18 A. if the provider participates in one or more of  
19 the health insurance carrier's commercial networks, the median  
20 amount of any commercial in-network reimbursement rates. The  
21 health insurance carrier shall provide information regarding  
22 this median amount to the provider;

23 B. the usual, customary and reasonable rate for  
24 services. As used in this subsection, "usual, customary and  
25 reasonable rate" means the sixtieth percentile of the allowed

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1 reimbursement rate for the particular health care service  
2 performed by a provider in the same or similar specialty in the  
3 same geographic area, as reported in a benchmarking database  
4 maintained by a nonprofit organization specified by the  
5 superintendent. The usual, customary and reasonable  
6 reimbursement rate shall not increase by more than three  
7 percent per year. The nonprofit organization shall be  
8 conflict-free and unaffiliated with any stakeholder in the  
9 health care sector; or

10 C. one hundred fifty percent of the rate at which  
11 the service would be reimbursed under the medicare fee  
12 schedule."

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

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

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

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

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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, service or ambulance transportation service 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;

- 1 (c) a cancer treatment center;  
2 (d) a birth center;  
3 (e) an inpatient, outpatient or  
4 residential drug and alcohol treatment center;  
5 (f) a laboratory, diagnostic or other  
6 outpatient medical service or testing center;  
7 (g) a health care provider's office or  
8 clinic;  
9 (h) an urgent care center;  
10 (i) a freestanding emergency room; or  
11 (j) any other therapeutic health care  
12 setting;

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

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

- 23 (a) an accident-only policy;  
24 (b) a credit-only policy;  
25 (c) a long- or short-term care or

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1 disability income policy;

2 (d) a specified disease policy;

3 (e) coverage provided pursuant to Title  
4 18 of the federal Social Security Act, as amended;

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

8 (g) a fixed indemnity policy;

9 (h) a dental-only policy;

10 (i) a vision-only policy;

11 (j) a workers' compensation policy;

12 (k) an automobile medical payment  
13 policy; or

14 (l) any other policy specified in rules  
15 of the superintendent;

16 (6) "health care services" means any service,  
17 supply or procedure for the diagnosis, prevention, treatment,  
18 cure or relief of a health condition, illness, injury or other  
19 disease, including physical or behavioral health services, to  
20 the extent offered by a health benefits plan;

21 (7) "health insurance carrier" means an entity  
22 subject to state insurance laws, including a health insurance  
23 company, a health maintenance organization, a hospital and  
24 health service corporation, a provider service network, a  
25 nonprofit health care plan or any other entity that contracts

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1 or offers to contract, or enters into agreements to provide,  
2 deliver, arrange for, pay for or reimburse any costs of health  
3 care services or that provides, offers or administers a health  
4 benefit policy or managed health care plan in the state;

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

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

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

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

25 (12) "provider" means a health care

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1 professional, hospital or other facility licensed to furnish  
2 health care services; and

3 (13) "surprise bill":

4 (a) means a bill that a nonparticipating  
5 provider issues to a covered person for health care services  
6 rendered in the following circumstances, in an amount that  
7 exceeds the covered person's cost-sharing obligation that would  
8 apply for the same health care services if these services had  
9 been provided by a participating provider: 1) emergency care  
10 provided by the nonparticipating provider; or 2) health care  
11 services, that are not emergency care, rendered by a  
12 nonparticipating provider at a participating facility where a:  
13 participating provider is unavailable; a nonparticipating  
14 provider renders unforeseen services; or a nonparticipating  
15 provider renders services for which the covered person has not  
16 given specific consent for that nonparticipating provider to  
17 render the particular services rendered; and

18 (b) does not mean a bill: 1) for health  
19 care services received by a covered person when a participating  
20 provider was available to render the health care services and  
21 the covered person knowingly elected to obtain the services  
22 from a nonparticipating provider without prior authorization;  
23 or 2) received for health care services rendered by a  
24 nonparticipating provider to a covered person whose coverage is  
25 provided pursuant to a preferred provider plan; provided that

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underscoring material = new  
~~[bracketed material] = delete~~

1 the health care services are not provided as emergency care."

2 SECTION 15. A new section of Chapter 59A, Article 16 NMSA  
3 1978 is enacted to read:

4 "[NEW MATERIAL] EMPLOYEE RETIREMENT INCOME SECURITY ACT OF  
5 1974 PLAN EXEMPT FROM STATE JURISDICTION--OPT-IN.--A large  
6 group or self-insured health plan offered in accordance with  
7 the provisions of the federal Employee Retirement Income  
8 Security Act of 1974 that is exempt from regulation under the  
9 New Mexico Insurance Code may adopt the provisions of the  
10 Surprise Billing Protection Act. The office of superintendent  
11 of insurance shall post on its website in a manner that is  
12 accessible to the public, information on which exempt large  
13 group and self-insurance health plans follow the provisions of  
14 the Surprise Billing Protection Act."

15 SECTION 16. CONTINGENT REPEAL.--Upon certification by the  
16 superintendent of insurance to the director of the legislative  
17 council service and the New Mexico compilation commission that  
18 the office of superintendent of insurance has adopted and  
19 promulgated rules to establish benchmarks for health insurance  
20 carriers to follow when making reimbursement to health care  
21 providers for services provided under circumstances that give  
22 rise to surprise billing in accordance with the Surprise  
23 Billing Protection Act, Section 13 of this act is repealed.

24 SECTION 17. EFFECTIVE DATE.--The effective date of the  
25 provisions of this act is October 1, 2019.

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