SENATE BILL 346

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

INTRODUCED BY

Gerald Ortiz y Pino

AN ACT

RELATING TO HEALTH INSURANCE; LIMITING PATIENT LIABILITY TO NONPARTICIPATING PROVIDERS FOR A BALANCE BILL; ESTABLISHING A FRAMEWORK FOR REIMBURSEMENT OF NONPARTICIPATING PROVIDERS OF EMERGENCY CARE; PROHIBITING BALANCE BILLING WITHOUT WRITTEN AGREEMENT OF THE PATIENT; INCREASING THE RATE OF INTEREST DUE FOR LATE PAYMENT OF CLEAN CLAIMS; REQUIRING REPORTING ON NETWORK ADEQUACY.

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

SECTION 1. Section 59A-16-21.1 NMSA 1978 (being Laws 2000, Chapter 58, Section 1, as amended) is amended to read:

"59A-16-21.1. HEALTH PLAN REQUIREMENTS--PAYMENT TO ELIGIBLE PROVIDERS.--

A. As used in this section:

(1) "allowable amount" means the price agreed

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to by a health plan and a participating provider for a health care service, including the amount of cost sharing required of a covered person for the service;

(2) "benchmarking organization" means a nonprofit organization that maintains a statistically representative benchmarking database of allowable amounts and billed charges for particular health care services in the same geographic area and that has been designated by the office to be used to establish the amount of reimbursement of a nonparticipating provider;

[~~(1)~~] (3) "clean claim" means a manually or electronically submitted claim from an eligible provider that:

(a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system;

(b) is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; and

(c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within thirty days of the date of receipt if submitted electronically or forty-five days if submitted manually;

[~~(2)~~] (4) "eligible provider" means [~~an~~

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~~individual or entity~~] a person that:

(a) is a participating provider;

(b) a health plan has credentialed after assessing and verifying the provider's qualifications; [~~or~~]

(c) a health plan is obligated to reimburse for claims in accordance with the provisions of: 1) Subsection G of Section 59A-22-54 NMSA 1978; 2) Subsection G of Section 59A-23-14 NMSA 1978; 3) Subsection G of Section 59A-46-54 NMSA 1978; or 4) Subsection G of Section 59A-47-49 NMSA 1978; or

(d) is a nonparticipating provider that the health plan is obligated to reimburse pursuant to the terms and conditions of a health benefits plan;

(5) "emergency care":

(a) means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to the covered person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a covered person regardless of the final diagnosis rendered to the covered person; and

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(b) includes emergency department services rendered after the patient's emergency condition has stabilized and inpatient services if a patient is subsequently admitted to the hospital through the hospital's emergency department;

(6) "health benefits plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health plan 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:

(a) an accident-only policy;

(b) a credit-only policy;

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

(d) a specified disease policy;

(e) a medicare or medicare supplement policy;

(f) medicaid;

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

(h) a fixed indemnity policy;

(i) a dental-only policy;

(j) a vision-only policy;

(k) a workers' compensation policy;

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(l) an automobile medical payment policy;

(m) an employee welfare benefit plan established under the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001 et seq., as amended; and

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

[~~(3)~~] (7) "health plan" means one of the following entities or its agent: health maintenance organization, nonprofit health care plan, provider service network or third-party payer; [~~and~~]

(8) "medicaid" means the joint federal-state program administered by the human services department pursuant to Title 19 or Title 21 of the federal Social Security Act;

(9) "medicare" means coverage under Part A, Part B, Part C or Part D of Title 18 of the federal Social Security Act;

(10) "medicare supplement" means coverage regulated pursuant to the Medicare Supplement Act, which coverage is intended to supplement medicare coverage;

(11) "nonparticipating provider" means an eligible provider that is not participating in a health plan's provider network;

(12) "office" means the office of

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superintendent of insurance;

[~~(4)~~] (13) "participating provider" means [~~an individual or entity~~] a person participating in a health plan's provider network; and

(14) "same geographic area" means New Mexico and the states contiguous to New Mexico.

B. A health plan shall provide for payment of interest on the plan's liability at the rate of [~~one and one-half~~] six percent a month on:

(1) the amount of a clean claim electronically submitted by the eligible provider and not paid within thirty days of the date of receipt; and

(2) the amount of a clean claim [~~manually submitted~~] that was not submitted electronically by the eligible provider and that was not paid within forty-five days of the date of receipt.

C. If a health plan is unable to determine liability for or refuses to pay a claim of an eligible provider within the times specified in Subsection B of this section, the health plan shall make a good-faith effort to notify the eligible provider by fax, electronic or other written communication within thirty days of receipt of the claim if submitted electronically, or forty-five days if not submitted [~~manually~~] electronically, of all specific reasons why it is not liable for the claim or that specific information is

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required to determine liability for the claim.

D. The interest due from a health plan on a claim that is not timely paid pursuant to Subsection B of this section shall be paid at the time the late claim itself is paid.

E. With respect to emergency care, a health plan shall pay and the nonparticipating provider shall accept an amount equal to the lowest of the:

(1) amount proposed by the nonparticipating provider; or

(2) average of the sixtieth percentile of the billed charges and the fiftieth percentile of the allowable amount for the particular health care service performed by providers in the same or similar specialty in the same geographic area most recently published by a benchmarking organization as of December 31, 2017, and, beginning on January 1, 2020, adjusted by an amount equal to the annual change, if any, in the most recent consumer price index for medical care published by the United States department of labor.

F. For health care services provided by a nonparticipating provider and covered under a health benefits plan, policy, contract or certificate delivered or issued for delivery or renewed, extended or amended in this state on or after July 1, 2019, the allowable amount shall be determined using the most recent allowable amount benchmarks based on

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twelve consecutive months of data published by a benchmarking organization. Thereafter, the allowable amounts shall be determined using the benchmarking organization's most recently published allowable amount benchmarks based on twelve consecutive months of data.

G. Rates of reimbursement established by medicare or medicaid shall not be considered in determining or calculating the allowable amount pursuant to Paragraph (2) of Subsections E and F of this section.

[~~D.~~] H. No contract between a health plan and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

[~~E.~~] I. The office [~~of superintendent of insurance~~], with input from interested parties, including health plans and eligible providers, shall promulgate rules to require health plans to provide:

(1) timely eligible provider access to claims status information;

(2) processes and procedures for submitting claims and changes in coding for claims;

(3) standard claims forms; and

(4) uniform calculation of interest.

J. No later than January 1, 2020, the office shall promulgate rules that:

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(1) ensure that each health plan makes prompt payment to each eligible provider for clean claims, including interest on outstanding amounts due for clean claims as required by Subsections B and D of this section;

(2) designate the benchmarking organization whose allowable amount benchmarking database will be used to establish the amount of reimbursement of a nonparticipating provider pursuant to Subsection E of this section. The benchmarking organization shall:

(a) not be affiliated with a health plan, health care provider or governmental entity;

(b) be certified as a qualified entity by the centers for medicare and medicaid services and receive all medicare parts A, B and D data from all fifty states; and

(c) have a statistically representative data set of claims from health plans for health care services performed by providers in the same or similar specialty in the same geographic area for the preceding four years; and

(3) make the data from the benchmarking database referred to in Paragraph (2) of this subsection available and accessible to all persons.

K. Beginning on January 31, 2020 and each January 31 thereafter, the office shall require each health benefits plan to certify the following for the previous calendar year:

(1) the number and types of unduplicated

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participating providers in the health benefits plan's health care provider network as of the first day of each month;

(2) the number and types of unduplicated nonparticipating providers to which the health plan has made payment as of the first day of each month; and

(3) compliance with the office's requirements, in both statute and rule, for health care provider network adequacy.

L. The reporting required in Subsection K of this section shall be public information.

M. By July 1, 2020 and by each July 1 thereafter, the office shall:

(1) solicit public comment on the methodology for reimbursement of nonparticipating providers pursuant to this section; and

(2) provide a written report to the governor and the legislature to include, at a minimum:

(a) the number and types of unduplicated participating providers in each health benefits plan's health care provider network as of the first day of each month of the previous calendar year;

(b) the number and types of unduplicated nonparticipating providers to which each health plan has made payment as of the first day of each month of the previous calendar year; and

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(c) a summary of public comments received regarding the methodology for reimbursement of nonparticipating providers pursuant to this section.

N. By July 1, 2021 and by each July 1 thereafter, the office shall contract for a random and independent audit of at least one health benefits plan covering the previous calendar year to determine its compliance with the methodology for reimbursement of nonparticipating providers pursuant to this section and its compliance with requirements in both statute and rule for health care provider network adequacy. The findings of this audit shall be public.

O. By July 1, 2021 and by each July 1 thereafter, the office shall provide an annual written report to the governor and the legislature of the findings of random and independent audits conducted pursuant to Subsection N of this section."

SECTION 2. Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3, as amended) is amended to read:

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

A. "balance bill" means a demand for payment:

(1) made by a nonparticipating provider to a covered person for payment of the difference between the amount of the nonparticipating provider's usual and customary charge for a service and the amount that a covered person's health

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benefits plan has paid or agreed to pay the nonparticipating provider for such services; and

(2) exceeding the amount that the patient is obligated to pay for covered out-of-network health care services under the terms of the patient's health insurance policy;

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

[~~B.~~] C. "covered person", "enrollee", "patient" or "consumer" means [~~an individual~~] a person who is entitled to receive health care benefits provided by a [~~managed~~] health care [~~plan~~] insurer;

[~~C.~~] D. "department" or "office" means the office of superintendent of insurance;

[~~D.~~] E. "emergency care":

(1) means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a covered person's health, serious

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impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to [~~a~~] the covered person regardless of the final diagnosis rendered to the covered person; and

(2) includes emergency department services rendered after the patient's emergency condition has stabilized and inpatient services if a patient is subsequently admitted to the hospital through the hospital's emergency department;

F. "health benefits plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health care insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

[~~E.~~] G. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting;

[~~F.~~] H. "health care insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, [~~health maintenance organization, nonprofit health care plan or prepaid dental plan~~] including a health insurance company, fraternal benefit society, vision plan or prepaid dental plan, health maintenance

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organization, hospital and health service corporation, provider service network, nonprofit health care plan, third party or any other person that contracts 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 health benefits plans and managed health care plans in this state;

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

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

[~~I.~~] K. "health care services" includes, to the extent offered by [~~the~~] a health benefits plan, physical health or community-based mental health or developmental disability services, including services for developmental delay;

[~~J.~~] L. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned,

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under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit or specified disease policies;

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

M. "nonparticipating provider" means a person not participating in a health benefits plan's provider service network;

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

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

[~~N.~~] P. "superintendent" means the superintendent

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of insurance; and

[~~O.~~] Q. "utilization review" means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients."

SECTION 3. A new section of the Patient Protection Act is enacted to read:

"[NEW MATERIAL] PROHIBITION ON BALANCE BILLING--VIOLATION OF THE PATIENT PROTECTION ACT.--

A. A covered person may agree in writing to pay a balance bill if the nonparticipating provider has disclosed the estimated amount of the balance bill to the covered person.

B. In the absence of a written agreement of a covered person in accordance with Subsection A of this section, a covered person shall not be liable for a balance bill.

C. In the absence of a written agreement of a covered person in accordance with Subsection A of this section, a person who seeks or accepts payment from a covered person for a balance bill violates the Patient Protection Act."

SECTION 4. APPLICABILITY.--

A. The provisions of Section 59A-16-21.1 NMSA 1978 apply to health benefits plans, policies, contracts and certificates delivered or issued for delivery or renewed, extended or amended in this state on or after July 1, 2019 for the following:

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(1) group health insurance governed by the provisions of the Health Care Purchasing Act;

(2) individual health insurance policies, health care plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;

(3) group and blanket health insurance policies, health care plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

(4) individual and group health maintenance organization plan contracts governed by the provisions of the Health Maintenance Organization Law; and

(5) individual and group nonprofit health care plan contracts governed by the provisions of the Nonprofit Health Care Plan Law.

B. The provisions of Section 3 of this act apply to health care services rendered on or after July 1, 2019.

SECTION 5. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2019.

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