

SENATE JUDICIARY COMMITTEE SUBSTITUTE FOR  
SENATE BILL 17

**56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023**

AN ACT

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

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

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

"NEW MATERIAL DENTAL COVERAGE--PRIOR AUTHORIZATION.--

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

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1 request submitted by a provider using a format prescribed by a  
2 dental plan.

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

8 C. Group coverage, including any form of self-  
9 insurance, offered, issued or renewed under the Health Care  
10 Purchasing Act that offers a dental plan shall not deny any  
11 claim subsequently submitted for services included in a prior  
12 authorization unless one of the following circumstances applies  
13 for each service denied:

14 (1) benefit limitations, including annual  
15 maximums or frequency limitations, not applicable at the time  
16 of the prior authorization, are reached due to the insured's  
17 utilization subsequent to issuance of the prior authorization;

18 (2) the documentation submitted for the claim  
19 clearly fails to support the claim as originally authorized;

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

25 (4) subsequent to the issuance of a prior

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1 authorization, new services are provided to the insured or a  
2 change in the insured's condition occurs such that the prior-  
3 authorized procedure would at that time require disapproval  
4 pursuant to the terms and conditions for coverage under the  
5 insured's plan in effect at the time the request for prior  
6 authorizations was made; or

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

9 (a) another entity is responsible for  
10 payment;

11 (b) the provider has already been paid  
12 for the services identified on the claim;

13 (c) the claim submitted was fraudulent;

14 (d) the prior authorization was based on  
15 erroneous information provided to the dental plan by the  
16 provider, the insured or other person; or

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

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

23 "[NEW MATERIAL] DENTAL COVERAGE--DESIGNATION OF PAYMENT.--

24 A. Group coverage, including any form of self-  
25 insurance, offered, issued or renewed under the Health Care

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1 Purchasing Act that offers a dental plan shall provide for the  
2 direct payment of covered benefits to a provider, specified by  
3 the insured, regardless of the provider's network or  
4 contractual status with the dental plan.

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

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

10 (2) an attestation to be completed by the  
11 insured."

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

14 "[NEW MATERIAL] DENTAL COVERAGE--ERRONEOUSLY PAID CLAIMS--  
15 RESTRICTIONS ON RECOVERY.--

16 A. Group coverage, including any form of self-  
17 insurance, offered, issued or renewed under the Health Care  
18 Purchasing Act that offers a dental plan shall establish  
19 policies and procedures for payment recovery, including  
20 providing:

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

23 (2) an explanation of the recovery being  
24 sought; and

25 (3) an opportunity for the provider to appeal

1 the recovery being sought as set forth in Subsection C of this  
2 section.

3 B. Group coverage, including any form of self-  
4 insurance, offered, issued or renewed under the Health Care  
5 Purchasing Act that offers a dental plan shall not initiate  
6 payment recovery procedures more than twenty-four months after  
7 the original payment for a claim was made unless the claim was  
8 fraudulent or intentionally misrepresented.

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

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

16 (2) advises the provider that an automatic  
17 deduction shall occur within forty-five days of receiving  
18 notification unless the provider submits a written appeal to  
19 the plan pursuant to the grievance rules prescribed by the  
20 superintendent of insurance.

21 D. The provisions of this section shall not apply  
22 to duplicate payments."

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

25 "[NEW MATERIAL] DENTAL COVERAGE--METHODS OF PAYMENT.--

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

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

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

8           B. Group coverage, including any form of self-  
9 insurance, offered, issued or renewed under the Health Care  
10 Purchasing Act that offers a dental plan shall not place  
11 restrictions on a provider regarding acceptable methods of  
12 payment, including designating credit card payments as the only  
13 acceptable form of payment.

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

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

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

21                   (3) shall provide a provider with a fee-free  
22 method of transmitting a payment and provide instructions for  
23 utilizing the method."

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

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1 "[NEW MATERIAL] DENTAL COVERAGE--PROVIDER NETWORK

2 LEASING.--

3 A. For purposes of this section:

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

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

9 (3) "provider network contract" means a  
10 contract between a contracting entity and a provider specifying  
11 the rights and responsibilities of the contracting entity and  
12 providing for the delivery of and payment for services to the  
13 insured; and

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

18 B. At a time when a contract relevant to granting  
19 access to a provider network to a third party is entered into  
20 or renewed, or when there are material modifications made, a  
21 contracting entity shall not require a provider to participate  
22 in third-party access to the provider network contract or  
23 contract directly with a third party that acquired the provider  
24 network. If a provider opts out, the contracting entity shall  
25 not cancel or otherwise end a contractual relationship with the

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underscoring material = new  
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1 provider. When initially contracting with a provider, a  
2 contracting entity must accept a qualified provider even if the  
3 provider rejects a network lease provision.

4 C. A contracting entity shall not grant a third  
5 party access to a provider network contract, a provider's  
6 services or discounts provided pursuant to a provider network  
7 contract unless:

8 (1) the provider network contract states that  
9 the contracting entity may enter into an agreement with a third  
10 party, allowing the third party to obtain the insurer's rights  
11 and responsibilities as though the third party were the  
12 contracting entity;

13 (2) the third party accessing the provider  
14 network contract agrees to comply with all of the terms of the  
15 provider network contract; and

16 (3) the contracting entity:

17 (a) identifies all third parties with  
18 which it contracts in a list on its website that is updated  
19 every ninety days;

20 (b) notifies a provider that a new third  
21 party is planning to lease or purchase the provider network  
22 contract, at least thirty business days before the lease or  
23 purchase takes effect;

24 (c) requires the third party to identify  
25 the source of the discount on all remittances or explanation of



1 benefits under which the discount is taken; and

2 (d) makes available a copy of the  
3 provider network contract relied upon in the adjudication of a  
4 claim to a provider within thirty days of the provider's  
5 request.

6 D. A third party's right to a provider's discounted  
7 rate shall cease upon the termination date of the provider  
8 network contract.

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

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

18 "59A-23G-1. SHORT TITLE.--~~[Sections 1 through 6 of this~~  
19 ~~act]~~ Chapter 59A, Article 23G NMSA 1978 may be cited as the  
20 "Short-Term Health Plan and Excepted Benefit Act".

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

23 "[NEW MATERIAL] DENTAL PLAN--PRIOR AUTHORIZATION.--

24 A. For purposes of this section, "prior  
25 authorization" means a written communication indicating whether

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1 a specific service is covered or multiple services are covered  
2 and reimbursable at a specific amount, subject to applicable  
3 coinsurance and deductibles, and issued in response to a  
4 request submitted by a provider using a format prescribed by a  
5 dental plan.

6 B. A dental plan shall provide a prior  
7 authorization upon the submission of a properly formatted  
8 request from a covered person.

9 C. A dental plan shall not deny any claim  
10 subsequently submitted for services included in a prior  
11 authorization unless one of the following circumstances applies  
12 for each service denied:

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

18 (2) the documentation submitted for the claim  
19 clearly fails to support the claim as originally authorized;

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

25 (4) subsequent to the issuance of a prior

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1 authorization, new services are provided to the covered person  
2 or a change in the covered person's condition occurs such that  
3 the prior-authorized procedure would at that time require  
4 disapproval pursuant to the terms and conditions for coverage  
5 under the covered person's plan in effect at the time the  
6 request for prior authorization was made; or

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

9 (a) another entity is responsible for  
10 payment;

11 (b) the provider has already been paid  
12 for the services identified on the claim;

13 (c) the claim submitted was fraudulent;

14 (d) the prior authorization was based on  
15 erroneous information provided to the dental plan by the  
16 provider, the covered person or other person; or

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

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

23 "[NEW MATERIAL] DENTAL PLAN--DESIGNATION OF PAYMENT.--

24 A. A dental plan shall provide for the direct  
25 payment of covered benefits to a provider, specified by a

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underscoring material = new  
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1 covered person, regardless of the provider's network or  
2 contractual status with the dental plan.

3 B. A dental plan shall provide for the direct  
4 payment of covered benefits to a provider, specified by a  
5 covered person, by including on its claim forms an:

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

8 (2) an attestation to be completed by the  
9 covered person."

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

12 "[NEW MATERIAL] DENTAL PLAN--ERRONEOUSLY PAID CLAIMS--  
13 RESTRICTIONS ON RECOVERY.--

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

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

18 (2) an explanation of the recovery being  
19 sought; and

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

23 B. A dental plan shall not initiate payment  
24 recovery procedures more than twenty-four months after the  
25 original payment for a claim was made unless the claim was

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1 fraudulent or intentionally misrepresented.

2 C. A dental plan shall not attempt to recover an  
3 erroneously paid claim by withholding or reducing payment for a  
4 different claim unless the plan:

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

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

12 D. The provisions of this section shall not apply  
13 to duplicate payments."

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

16 "[NEW MATERIAL] DENTAL PLAN--METHODS OF PAYMENT.--

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

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

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

25 B. A health insurance carrier shall not place

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1 restrictions on a provider regarding acceptable methods of  
2 payment, including designating credit card payments as the only  
3 acceptable form of payment.

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

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

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

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

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

16 "[NEW MATERIAL] DENTAL PLAN--PROVIDER NETWORK LEASING.--

17 A. For purposes of this section:

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

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

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

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1 providing for the delivery of and payment for services to  
2 covered persons; and

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

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

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

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

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1 were the contracting entity;

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

5 (3) the contracting entity:

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

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

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

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

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

23 E. The provisions of this section shall not apply  
24 if access to a provider network contract is granted to a dental  
25 carrier of an entity operating in accordance with the same

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

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

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