F I S C A L I M P A C T R E P O R T

SPONSOR Ortiz y Pino **ORIGINAL DATE** 2/4/19 **LAST UPDATED** **HB**

SHORT TITLE Health Plan Billing **SB** 346

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		See Fiscal Implications				

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to SB279/HB 295, HB207/SB337, HB 436, SB188, SB354

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
Public School Insurance Authority (PSIA)
Retiree Health Care Authority (RHCA)
Human Services Department (HSD)
Albuquerque Public Schools (APS)

SUMMARY

Synopsis of Bill

Senate Bill 346 would make a number of changes to Section 59A, NMSA 1978, the Insurance Code, the majority having to do with "balance billing," which is defined in the bill as "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 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."

The sections of the bill, the portions of Section 59A NMSA 1978 affected by it, and the provisions made are as follows:

Section of Bill	Part of Section 59A Affected	Provisions
1A	59A-16-21.1	New definitions, including of 1. "benchmarking organization:" A non-governmental, non-profit organization that maintains a database of prices for health care services within the area in and near New Mexico and designated by OSI to determine appropriate reimbursement to a non-participating provider for a given service. 2. "allowable amount:" the price agreed upon by an insurer and a participating practitioner 3. "emergency care:" Services to patient who could "reasonably expect" serious consequences if care were not delivered right away 4. "health benefits plan:" health insurance products not including short-term, travel, dental, TRICARE, ERISA coverage, vision-only and dental-only plans, etc. 5. "non-participating provider:" provider not participating in a given insurer's network (as opposed to "participating provider.
1B		Assesses interest of insurers to be paid to providers with clean claims not paid within 30 days of electronic receipt, or 45 days if non-electronically submitted.
1C		Requires insurers to make a "good faith effort" to communicate reasons for non-payment within the same timelines as in B.
1D		Interest under B is to be paid when the claim is paid.
1E		Establishes rules for calculating payments to non-participating providers for emergency care, based either on that provider's usual charges or on the charges identified as typical in the area by the benchmarking organization.
1F		Establishes payment methodology for non-emergency care by non-participating providers
1G		Medicaid and Medicare reimbursement are <u>not</u> to be used as a benchmark.
1H		unchanged
1I		unchanged
1J		Rules to be promulgated by OSI to designate a benchmarking organization and make public its findings, be sure that prompt payment for clean claims occurs,
1K, 1L		OSI to require insurers to provide information on payments to nonparticipating providers, and to make those findings public.
1M		OSI to report to the governor and legislature on public comment on its rules and the findings from the data collected pursuant to Section 1K.
1N, 1O		Contract for an audit of at least one insurer's compliance with the act, and make the audit's findings public. Provide a report to Governor and Legislature of the audit's findings.

2	59A-57-3	Definition of "balance bill" and "emergency care" "participating and non-participating providers" as above,
3	59A-57-1	Balance billing would be prohibited unless a covered person has agreed to it in writing.
4, 5		Effective and applicable to all health insurers for products delivered after July 1, 2019

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 346.

OSI, to which the tasks envisioned in this bill would fall, estimates its costs as follows:

> OSI currently does not have the required staffing to fulfill the rulemaking, data collection and reporting requirements mandated by this legislation. OSI has never received funding for staff for enforcement of provider complaints and clean claims statutes. OSI projects that the reporting requirements will entail additional staffing:
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> ½ FTE monthly data collection- $30k salary plus benefits
> 1 FTE analysis and reporting on network adequacy and reimbursement compliance - $85k salary plus benefits
> 1 FTE attorney to issue rulemaking and handle enforcement actions against carriers for provider complaints - $100k
> 3 FTE to handle provider complaints and ensure compliance with reimbursement and reporting requirements - $65k each salary plus benefits = $195k
>
> Total staffing costs for 2019 - $295k. Total staffing costs for 2020 and beyond, $410k
>
> The legislation also requires OSI to contract for an audit of carrier compliance with reimbursement standards for nonparticipating providers. Based on prior, similar contracts issued, OSI anticipates that this contract will cost $150,000 annually. This amount will be triggered in 2021.

SIGNIFICANT ISSUES

HSD notes that Medicaid is excluded from provisions of this bill, and also that Medicaid patients are already protected from balance billing for covered services.

OSI points out that the "emergency care" definition is broader than is usual. It indicates that the interest rates anticipated in the bill might drive up premium costs [or might induce insurers to pay promptly].

OSI comments as well on the effect of using a benchmarking standard as proposed in Section 1E of the bill:

> By basing the benchmark on either whatever rate the provider proposes or an average of billed charges and allowed amounts, the proposed benchmark largely eliminates any downward pressures applied to controlling health care costs. This creates disincentives for provider participation in health plan networks if providers are able to leverage more money for out-of-network care than in network care. Additionally, states that have benchmarked out-of-network payments on billed charges have seen an inflationary

increase in the cost of health care services that may be the result of a benchmark based on billed charges. For example, in 2013, the Texas Department of Insurance adopted new regulations requiring PPO plans to pay the 50th percentile of billed charges using an independent database. Since 2013, Texas has observed increases in ER charges between 80% and 102%. (Data provided to the Texas Association of Health Plans by Fair Health). While the legislation tries to create an adjustment for inflation, the way the legislation is written, this adjustment for legislation is a floor rather than a ceiling through which payment rates can be increased. Given the increasing deductibles impacting consumers who have insurance in New Mexico, OSI seriously cautions adoption of this methodology for payment of out-of-network claims.

OSI also has serious concerns that the legislation does not address out-of-network non-emergent care. In a 2017 online survey conducted by OSI in partnership with the Office of the Superintendent of Insurance, 36 percent of individuals who had anticipated surgery received a surprise out-of-network bill.

Section 3 weakens current protections under the Patient Protection Act that currently requires that insurance carriers must hold consumers harmless for out-of-network emergency care. This legislation allows for consumers to waive that provision upon some form of notice by the provider. This provision also weakens current New Mexico regulation that requires insurance companies to hold consumers harmless for out-of-network non-emergent care received, generally with prior authorization, where no in-network provider is available. Under the proposed language, a consumer can waive this right.

ADMINISTRATIVE IMPLICATIONS

OSI currently does not have the required staffing to fulfill the rulemaking, data collection and reporting requirements mandated by this legislation. OSI has never received funding for staff for enforcement of provider complaints and clean claims statutes.

OSI notes that this legislation does not contain any enforcement authority requiring providers to accept payment, including benchmark payment for surprise medical bills.

RELATIONSHIP with the following bills, all dealing with aspects of health care insurance coverage:
SB279/HB 295, the Health Security Act, enacting a single-payer system
HB207/SB337, the Surprise Billing Protection Act
HB 436, to Align Health Insurance Law with Federal Law
SB188, the Health Insurance Prior Authorization Act
SB354, on Health Coverage via Telehealth

AMENDMENTS

Enforcement of OSI mandates on providers and on insurers could be included in the bill.

LAC/al/sb