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\_\_\_\_\_ BILL

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

INTRODUCED BY

DISCUSSION DRAFT

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; ENACTING A NEW SECTION OF CHAPTER 59A, ARTICLE 16 NMSA 1978 TO PROHIBIT SURPRISE BILLING AS AN UNFAIR PRACTICE; ESTABLISHING PENALTIES.

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:

"[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:

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

3            A. "ambulance service" means any government or  
4 private ground transportation service designated and used, or  
5 intended to be used, for the transportation of sick or injured  
6 persons;

7            B. "balance billing" means a provider's practice of  
8 billing a covered person for the difference between the  
9 provider's billed charges and the health insurance carrier's  
10 limit for reimbursement of provider charges;

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

13           D. "co-insurance" means a cost-sharing method that  
14 requires a covered person to pay a stated percentage of medical  
15 expenses after any deductible amount is paid; provided that  
16 co-insurance rates may differ for different types of services  
17 under the same health benefits plan;

18           E. "copayment" means a cost-sharing provision that  
19 requires a covered person to pay a fixed dollar amount when  
20 health care services are received or when purchasing medicine  
21 after subtraction of any deductible, with the health insurance  
22 carrier paying the balance allowable amount; provided that  
23 there may be different copayment requirements for different  
24 types of services and a copayment may be subject to a maximum  
25 out-of-pocket limit;

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

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

9           H. "covered person" means:

10                   (1) an enrollee, policyholder or subscriber;

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

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

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

21           J. "emergency medical condition" means a physical  
22 or behavioral health condition that manifests itself by acute  
23 symptoms of sufficient severity, including severe pain, that  
24 would lead a prudent layperson in that circumstance, possessing  
25 an average knowledge of medicine and health, to reasonably

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1 expect, in the absence of immediate medical attention, to  
2 result in:

3 (1) placing the individual's physical or  
4 behavioral health or, with respect to a pregnant woman, the  
5 woman or a fetus' health in serious jeopardy;

6 (2) serious impairment of bodily function;

7 (3) serious impairment of any bodily organ or  
8 part; or

9 (4) with respect to a pregnant woman who is  
10 having contractions:

11 (a) providing inadequate time to effect  
12 a safe transfer to another hospital before or after delivery;  
13 or

14 (b) the transfer to another hospital may  
15 pose a threat to the health or safety of the woman or a fetus;

16 K. "emergency service" means, with respect to an  
17 emergency medical condition:

18 (1) a medical or mental health screening  
19 examination that is within the capacity of the emergency  
20 department of a hospital, including ancillary services  
21 routinely available to the emergency department of a hospital,  
22 to evaluate the emergency medical condition;

23 (2) any further medical or mental health  
24 examination and treatment to the extent that they are within  
25 the capabilities of the staff and facilities available at the

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1 emergency medical facility to stabilize the patient; and

2 (3) any transportation provided by ambulance  
3 to a hospital for emergency medical, mental or behavioral  
4 health treatment;

5 L. "facility" means an entity providing a health  
6 care service, including:

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

9 (2) an ambulatory surgical center;

10 (3) a cancer treatment center;

11 (4) a birth center;

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

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

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

17 (8) an urgent care center; or

18 (9) any other therapeutic health care setting;

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

25 (1) an accident-only policy;

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- 1 (2) a credit-only policy;
- 2 (3) a long- or short-term care or disability
- 3 income policy;
- 4 (4) a specified disease policy;
- 5 (5) coverage provided pursuant to Title 18 of
- 6 the federal Social Security Act, as amended;
- 7 (6) a federal TRICARE policy, including a
- 8 federal civilian health and medical program of the uniformed
- 9 services supplement;
- 10 (7) a fixed indemnity policy;
- 11 (8) a dental-only policy;
- 12 (9) a vision-only policy;
- 13 (10) a workers' compensation policy;
- 14 (11) an automobile medical payment policy; or
- 15 (12) any other policy specified in rules of
- 16 the superintendent;

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

22 O. "health insurance carrier" means an entity  
23 subject to state insurance laws, including a health insurance  
24 company, a health maintenance organization, a hospital and  
25 health service corporation, a provider service network, a

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

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

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

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

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

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

25 U. "participating provider" means a provider or

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1 facility that, under express contract with a health insurance  
2 carrier or with a health insurance carrier's contractor or  
3 subcontractor, has agreed to provide health care services to  
4 covered persons, with an expectation of receiving payment  
5 directly or indirectly from the health insurance carrier,  
6 subject to cost sharing;

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

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

16 X. "stabilize" means to provide medical or  
17 behavioral health treatment of a patient's emergency medical  
18 condition as may be necessary to ensure, within reasonable  
19 medical probability, that no material deterioration of the  
20 condition is likely to result from or occur during the transfer  
21 of the patient to a facility or, with respect to emergency  
22 labor, to deliver, including the delivery of a placenta; and

23 Y. "surprise bill":

24 (1) means a bill that a nonparticipating  
25 provider issues to a covered person for health care services

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1 rendered in the following circumstances, in an amount that  
2 exceeds the covered person's cost-sharing obligation that would  
3 apply for the same health care services if these services had  
4 been provided by a participating provider:

5 (a) emergency services or emergency  
6 ground transportation provided by the nonparticipating  
7 provider; or

8 (b) non-emergency services rendered by a  
9 nonparticipating provider at a participating facility where:

10 1) a participating provider is unavailable; 2) a  
11 nonparticipating provider renders unforeseen services; or 3) a  
12 nonparticipating provider renders services for which the  
13 covered person has not given specific consent for that  
14 nonparticipating provider to render the particular services  
15 rendered; and

16 (2) does not mean a bill:

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

23 (b) received for health care services  
24 rendered by a nonparticipating provider to a covered person  
25 whose coverage is provided pursuant to a preferred provider

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1 plan; provided that the health care services are not provided  
2 as emergency services."

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

5 "[NEW MATERIAL] EMERGENCY SERVICES--REIMBURSEMENT--  
6 LIMITATION ON CHARGES.--

7 A. A health insurance carrier shall reimburse a  
8 nonparticipating provider for emergency services necessary to  
9 evaluate and stabilize a covered person at a nonparticipating  
10 hospital emergency department if a prudent layperson would  
11 reasonably believe that:

12 (1) emergency services are necessary; and

13 (2) use of a participating hospital emergency  
14 department would result in a delay that would worsen the  
15 covered person's condition.

16 B. A health insurance carrier shall not require  
17 that prior authorization for emergency services be obtained by,  
18 or on behalf of, a covered person prior to the point of  
19 stabilization of that covered person if a prudent layperson  
20 would reasonably believe that an emergency medical condition  
21 exists.

22 C. A health insurance carrier may impose a  
23 copayment, co-insurance or limitation of benefits requirement  
24 for emergency services performed by a nonparticipating provider  
25 only to the same extent that the copayment, co-insurance or

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1 limitation of benefits requirement applies for participating  
2 providers and is documented in the policy.

3 D. A health insurance carrier may require an  
4 emergency services provider to notify a health insurance  
5 carrier of a covered person's admission to the hospital within  
6 a reasonable time period after stabilization of the emergency  
7 medical condition."

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

10 "[NEW MATERIAL] NON-EMERGENCY SERVICES--LIMITATION ON  
11 CHARGES.--

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

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

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

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1           B. Except as set forth in Subsection A of this  
2 section, nothing in this section shall preclude a provider from  
3 balance billing for non-emergency health care services provided  
4 by a nonparticipating provider to an individual with coverage  
5 through a health maintenance organization contract."

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

8           "[NEW MATERIAL] CREDIT AGAINST MAXIMUM OUT-OF-POCKET COST-  
9 SHARING AMOUNT--SURPRISE BILL COMPLAINT FORM--COMMUNICATION BY  
10 HOSPITALS--ADVANCE NOTIFICATION OF CHARGES FOR HEALTH CARE  
11 SERVICES.--

12           A. If a covered person receives a health care  
13 service from a nonparticipating provider under the conditions  
14 set forth in Section 3 or 4 of the Surprise Billing Protection  
15 Act, that provider shall not knowingly submit a surprise bill  
16 to the covered person. Upon request, the covered person's  
17 health insurance carrier shall submit to the nonparticipating  
18 provider a statement of the applicable in-network cost-sharing  
19 amounts owed by the covered person to the nonparticipating  
20 provider.

21           B. If a covered person receives a surprise bill,  
22 the covered person may submit a surprise bill complaint form to  
23 the covered person's health insurance carrier in accordance  
24 with the provisions of this section.

25           C. The superintendent shall:

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1 (1) develop a standardized surprise bill  
2 complaint form to permit a covered person to plead that a bill  
3 is a surprise bill; and

4 (2) post the form on the superintendent's  
5 website and distribute written copies to the public.

6 D. A health insurance carrier to which a covered  
7 person submits a surprise bill complaint form shall review the  
8 surprise bill complaint form in accordance with its grievance  
9 procedures established pursuant to the Patient Protection Act.

10 E. In accordance with the hearing procedures  
11 established pursuant to the Patient Protection Act, a covered  
12 person or a nonparticipating provider may appeal a health  
13 insurance carrier's determination made pursuant to the filing  
14 of a surprise bill complaint form.

15 F. A health insurance carrier may require a covered  
16 person who files a surprise bill complaint form to submit a  
17 statement and reasonable documentation attesting that the claim  
18 in question is a surprise bill that meets the definition under  
19 Subsection Y of Section 2 of the Surprise Billing Protection  
20 Act.

21 G. By December 31, 2019, the department of health  
22 shall require each health facility licensed pursuant to the  
23 Public Health Act to post the following on the health  
24 facility's website in a publicly accessible manner:

25 (1) the names and hyperlinks for direct access

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1 to the websites of all health benefits plans for which the  
2 hospital has a contract for services;

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

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

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

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

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

17 (4) instructions for contacting the  
18 superintendent.

19 H. Any communication pertaining to services  
20 provided under circumstances giving rise to a surprise bill  
21 shall clearly state that the covered person is responsible only  
22 for payment of applicable in-network cost-sharing amounts under  
23 the covered person's health benefits plan."

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

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

2           A. If a covered person pays a nonparticipating  
3 provider more than the in-network cost-sharing amount for  
4 services provided under circumstances giving rise to a surprise  
5 bill, the nonparticipating provider shall refund to the covered  
6 person within thirty calendar days of receipt any amount paid  
7 in excess of the in-network cost-sharing amount.

8           B. If a nonparticipating provider has not made a  
9 full refund to the covered person of any amount paid in excess  
10 of the in-network cost-sharing amount to the covered person  
11 within thirty calendar days of receipt, interest shall accrue  
12 at the rate of ten percent per year beginning with the first  
13 calendar day following the thirty-calendar-day period.

14           C. A covered person may seek recovery of the refund  
15 of the amount the covered person has paid in excess of the in-  
16 network cost-sharing amount that a nonparticipating provider  
17 owes, plus interest, pursuant to Subsection B of this section  
18 by bringing an action in district court to recover that  
19 overpayment amount and interest owed and reasonable costs and  
20 attorney fees, if approved by the court."

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

23           "[NEW MATERIAL] NONPARTICIPATING PROVIDERS--REBATES AND  
24 INDUCEMENTS--PROHIBITION.--A nonparticipating provider shall  
25 not, either directly or indirectly, knowingly waive, rebate,

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1 give, pay or offer to waive, rebate, give or pay all or part of  
2 a cost-sharing amount owed by a covered person pursuant to the  
3 terms of the covered person's health benefits plan as an  
4 inducement for the covered person to seek a health care service  
5 from that nonparticipating provider. The superintendent may  
6 impose fines on providers for unlawful rebates and inducements;  
7 provided that a provider on which the superintendent intends to  
8 impose a fine shall be entitled to a hearing in accordance with  
9 the provisions of Section 59A-4-15 NMSA 1978."

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

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

14 A. For services provided under circumstances giving  
15 rise to a surprise bill, a health insurance carrier shall  
16 reimburse a nonparticipating provider for emergency health care  
17 services rendered, the greatest of the following amounts:

18 (1) the median reimbursement rate the health  
19 benefits plan would cover for emergency services if rendered by  
20 a participating provider; or

21 (2) the usual, customary and reasonable rate  
22 for emergency services. As used in this paragraph, "usual,  
23 customary and reasonable rate" means [xxx] for the particular  
24 health care service performed by a provider in the same or  
25 similar specialty in the same geographic area, as reported in a

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1 benchmarking database maintained by a nonprofit organization  
2 specified by the superintendent. The nonprofit organization  
3 shall be conflict-free and unaffiliated with any stakeholder in  
4 the health care sector. Benchmarks for the usual, customary  
5 and reasonable rate shall be reviewed by the superintendent  
6 every two years to ensure fairness to providers and to evaluate  
7 the impact on health insurance premiums. The superintendent  
8 shall establish the benchmark threshold by rule.

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

13 C. A health insurance carrier shall reimburse a  
14 nonparticipating provider for non-emergency health care  
15 services rendered under circumstances giving rise to a surprise  
16 bill in the following manner:

17 (1) the health insurance carrier and  
18 nonparticipating provider may reach an agreement as to an  
19 amount to be paid for the nonparticipating provider's services,  
20 payment of which, in addition to the applicable in-network  
21 cost-sharing amount owed by the covered person, shall  
22 constitute payment in full to the nonparticipating provider for  
23 the health care service rendered, and the health insurance  
24 carrier shall pay the provider in accordance with requirements  
25 for prompt payment established pursuant to Section 59A-16-21.1

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1 NMSA 1978;

2 (2) if a nonparticipating provider and health  
3 insurance carrier do not reach agreement on a payment amount  
4 through the negotiation process outlined in this section within  
5 forty-five calendar days after the health insurance carrier  
6 receives the bill for the health care service, either party may  
7 submit a formal dispute resolution request to the  
8 superintendent and include all of the claims pertaining to a  
9 covered person from a single episode of illness;

10 (3) calculation of the date of health  
11 insurance carrier receipt of the bill shall align with  
12 requirements for prompt payment established pursuant to Section  
13 59A-16-21.1 NMSA 1978; and

14 (4) a health insurance carrier's failure to  
15 respond within forty-five days to a nonparticipating provider's  
16 request for prompt payment of a surprise bill shall constitute  
17 acceptance of the provider's charges. Payment of accepted  
18 charges shall be made in accordance with requirements for  
19 prompt payment established pursuant to Section 59A-16-21.1 NMSA  
20 1978.

21 D. A health insurance carrier shall make available  
22 to providers access to claims status information."

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

25 "[NEW MATERIAL] HEALTH INSURANCE CARRIERS--

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1 NONPARTICIPATING PROVIDERS--INDEPENDENT DISPUTE RESOLUTION FOR  
2 NON-EMERGENCY SERVICES CLAIMS--COSTS.--

3 A. A health insurance carrier or nonparticipating  
4 provider may initiate binding arbitration to determine  
5 reimbursement for non-emergency services provided by a  
6 nonparticipating provider. Failure to respond within fifteen  
7 business days to a request for arbitration constitutes an  
8 acceptance of the final claims settlement offer of the party  
9 requesting arbitration. Payment of accepted charges shall  
10 align with requirements for prompt payment established pursuant  
11 to Section 59A-16-21.1 NMSA 1978.

12 B. Arbitration shall be initiated by filing a  
13 request with the superintendent. The parties may agree to  
14 resolve disputes over additional reimbursement services for  
15 multiple covered persons during the arbitration process.

16 C. The superintendent shall publish a list of  
17 resolution organizations or arbitrators that provide binding  
18 arbitration.

19 D. Both parties shall agree on an arbitrator from  
20 the list within five business days of submission of a request  
21 for arbitration.

22 E. If no agreement can be reached, a list of five  
23 arbitrators will be provided. From the list of five  
24 arbitrators, the party initiating arbitration shall first veto  
25 two arbitrators and then the other party shall veto two

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1 arbitrators from the remaining list. The remaining arbitrator  
2 shall be the chosen arbitrator.

3 F. The party requesting arbitration shall notify  
4 the other party that arbitration has been initiated and state  
5 its final offer to resolve the dispute over reimbursement for  
6 services provided before arbitration occurs. In response to  
7 this notice, the non-requesting party shall inform the  
8 requesting party of its final offer before arbitration occurs.

9 G. The arbitrator's review shall consist of a  
10 review of both parties' final offers submitted to resolve the  
11 dispute over reimbursement for services. The arbitrator's  
12 decision may be one of the two amounts submitted by the parties  
13 as their final offers or another amount determined to be  
14 reasonable by the arbitrator. If the arbitrator finds that,  
15 given the final offers, a settlement between the health  
16 insurance carrier and the nonparticipating provider is  
17 reasonably likely or that the final offers represent  
18 unreasonable extremes, the arbitrator may direct both parties  
19 to attempt a good faith negotiation for settlement. The health  
20 insurance carrier and nonparticipating provider may be granted  
21 up to ten business days for this negotiation, which shall run  
22 concurrently with the thirty-day period for dispute resolution.

23 H. In making a determination pursuant to this  
24 section, the arbitrator may consider, and the parties shall  
25 provide at the resolution organization's request, documentation

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1 of the following:

2 (1) the individual covered person's  
3 characteristics;

4 (2) the level of training, education and  
5 experience of the nonparticipating provider;

6 (3) the nonparticipating provider's usual  
7 charge for comparable services provided out-of-network with  
8 respect to any health benefits plan;

9 (4) the participating provider contracted rate  
10 of payment for comparable services;

11 (5) the usual and customary provider charges,  
12 as defined by a public independent database of charges, for the  
13 same or similar services in the same geographic area;

14 (6) the amount that would be paid under health  
15 coverage pursuant to health coverage under part A or part B of  
16 Title 18 of the federal Social Security Act, as amended, or  
17 federal-state medical assistance provided pursuant to Title 19  
18 or 21 of the federal Social Security Act for the service;

19 (7) the circumstances and complexity of the  
20 particular case, including the time and the place of the  
21 service;

22 (8) the availability of the health care  
23 service for the covered person from participating providers;

24 (9) any payments made in prior surprise bill  
25 disputes between the provider and the health insurance carrier;

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1 and

2 (10) the propensity of the provider to be  
3 included in health insurance carrier networks.

4 I. The arbitrator shall issue a written decision  
5 within thirty business days after assignment of a matter for  
6 dispute for resolution. Copies of any written findings of fact  
7 shall be provided to both parties and the superintendent by the  
8 same means, whether electronic or hard copy.

9 J. The determination obtained through the  
10 resolution process pursuant to this section shall be binding on  
11 both parties and not appealable.

12 K. A final determination as to a claim code of a  
13 service shall be binding on the health insurance carrier and  
14 the provider for any disputes between them involving the same  
15 claim code for a period of one year from the date of the  
16 determination.

17 L. An arbitrator's expenses and fees, together with  
18 other expenses, excluding attorney fees, incurred in the  
19 conduct of arbitration shall be shared equally by the parties  
20 to the arbitration.

21 M. A party that fails to pay all amounts due to the  
22 other party and to the resolution organization within thirty  
23 business days of receiving the final determination shall:

24 (1) pay interest to the resolution  
25 organization and to the prevailing party at one and one-half

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1 percent per month; and

2 (2) be subject to a penalty of one hundred  
3 dollars (\$100) per day, payable to the current school fund,  
4 until all payments are made in full.

5 N. Nothing in this section shall preclude the  
6 parties from reaching a resolution of their dispute before the  
7 arbitrator issues its decision.

8 O. A resolution organization shall:

9 (1) protect from disclosure, including in the  
10 information provided to the superintendent, any information  
11 specifically identifying the covered person who received the  
12 health care services that were the subject of an arbitration  
13 decision. The information shall be protected and remain  
14 confidential in compliance with all applicable state and  
15 federal law and shall be confidential as a record pursuant to  
16 applicable state and federal law; and

17 (2) report to the superintendent any change in  
18 its status that would cause it to cease performing or being  
19 qualified to perform arbitrations pursuant to the Surprise  
20 Billing Protection Act."

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

23 "[NEW MATERIAL] REASONABLE HEALTH CARE COST MANAGEMENT  
24 PERMITTED.--Nothing in the Surprise Billing Protection Act  
25 shall be construed to prohibit a health insurance carrier from

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1 appropriately using reasonable health care cost management  
2 techniques."

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

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

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

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

13 A. shall promulgate rules as may be necessary to  
14 appropriately implement the provisions of the Surprise Billing  
15 Protection Act, including creation of a surprise billing  
16 complaint form; and

17 B. may require by rule that carriers report the  
18 annual percentage of claims and expenditures paid to  
19 nonparticipating providers for health care services."

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

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

25 A. group health coverage governed by the provisions



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1 of the Health Care Purchasing Act;

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

5 C. group and blanket health insurance policies,  
6 health benefits plans and certificates of insurance governed by  
7 the provisions of Chapter 59A, Article 23 NMSA 1978;

8 D. individual and group health maintenance  
9 organization contracts governed by the provisions of the Health  
10 Maintenance Organization Law; and

11 E. individual and group nonprofit health benefits  
12 plans governed by the provisions of the Nonprofit Health Care  
13 Plan Law."

14 SECTION 14. A new section of Chapter 59A, Article 16 NMSA  
15 1978 is enacted to read:

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

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

25 B. It shall be an unfair practice for a health care

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1 provider to submit a surprise bill to a collection agency.

2 C. As used in this section:

3 (1) "co-insurance" means a cost-sharing method  
4 that requires a covered person to pay a stated percentage of  
5 medical expenses after any deductible amount is paid; provided  
6 that co-insurance rates may differ for different types of  
7 services under the same health benefits plan;

8 (2) "copayment" means a cost-sharing provision  
9 that requires a covered person to pay a fixed dollar amount  
10 when health care services are received or when purchasing  
11 medicine after subtraction of any deductible, with the health  
12 insurance carrier paying the balance allowable amount; provided  
13 that there may be different copayment requirements for  
14 different types of services and a copayment may be subject to a  
15 maximum out-of-pocket limit;

16 (3) "cost sharing" means a copayment,  
17 co-insurance, deductible or any other form of financial  
18 obligation of a covered person other than a premium or share of  
19 a premium, or any combination of any of these financial  
20 obligations as defined by the terms of a health benefits plan;

21 (4) "covered person" means:

22 (a) an enrollee, policyholder or  
23 subscriber;

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

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

3 (5) "deductible" means a fixed dollar amount  
4 that a covered person may be required to pay during the benefit  
5 period before the health insurance carrier begins payment for  
6 covered benefits; provided that a health benefits plan may have  
7 both individual and family deductibles and separate deductibles  
8 for specific services;

9 (6) "emergency medical condition" means a  
10 physical or behavioral health condition that manifests itself  
11 by acute symptoms of sufficient severity, including severe  
12 pain, that would lead a prudent layperson in that circumstance,  
13 possessing an average knowledge of medicine and health, to  
14 reasonably expect, in the absence of immediate medical  
15 attention, to result in:

16 (a) placing the individual's physical or  
17 behavioral health or, with respect to a pregnant woman, the  
18 woman or a fetus' health in serious jeopardy;

19 (b) serious impairment of bodily  
20 function;

21 (c) serious impairment of any bodily  
22 organ or part; or

23 (d) with respect to a pregnant woman who  
24 is having contractions: 1) that there is inadequate time to  
25 effect a safe transfer to another hospital before or after

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1 delivery; or 2) the transfer to another hospital may pose a  
2 threat to the health or safety of the woman or a fetus;

3 (7) "emergency services" means, with respect  
4 to an emergency medical condition:

5 (a) a medical or mental health screening  
6 examination that is within the capacity of the emergency  
7 department of a facility, including ancillary services  
8 routinely available to the emergency department of a hospital,  
9 to evaluate the emergency medical condition;

10 (b) any further medical or mental health  
11 examination and treatment to the extent they are within the  
12 capabilities of the staff and facilities available at the  
13 emergency medical facility to stabilize the patient; and

14 (c) any transportation provided by  
15 ambulance to a hospital for emergency medical, mental or  
16 behavioral health treatment;

17 (8) "facility" means an entity providing a  
18 health care service, including:

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

21 (b) an ambulatory surgical center;

22 (c) a cancer treatment center;

23 (d) a birth center;

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

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

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

5 (h) an urgent care center; or

6 (i) any other therapeutic health care  
7 setting;

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

13 (a) an accident-only policy;

14 (b) a credit-only policy;

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

17 (d) a specified disease policy;

18 (e) coverage provided pursuant to Title  
19 18 of the federal Social Security Amendments of 1965, as then  
20 constituted or later amended;

21 (f) a federal TRICARE policy, including  
22 a federal civilian health and medical program of the uniformed  
23 services supplement;

24 (g) a fixed indemnity policy;

25 (h) a dental-only policy;

- 1 (i) a vision-only policy;
- 2 (j) a workers' compensation policy;
- 3 (k) an automobile medical payment
- 4 policy; or
- 5 (l) any other policy specified in rules
- 6 of the superintendent;
- 7 (10) "health care provider" means a health
- 8 care professional, hospital or other facility licensed to
- 9 furnish health care services;
- 10 (11) "health care services" means any service,
- 11 supply or procedure for the diagnosis, prevention, treatment,
- 12 cure or relief of a health condition, illness, injury or other
- 13 disease, including physical or behavioral health care services,
- 14 to the extent they are offered by a health benefits plan;
- 15 (12) "nonparticipating provider" means a
- 16 provider who is not a participating provider;
- 17 (13) "participating provider" means a provider
- 18 or facility that, under express contract with a health
- 19 insurance carrier or with a health insurance carrier's
- 20 contractor or subcontractor, has agreed to provide health care
- 21 services to covered persons, with an expectation of receiving
- 22 payment directly or indirectly from the health insurance
- 23 carrier, subject to cost sharing; and
- 24 (14) "surprise bill":
- 25 (a) means a bill that a nonparticipating

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1 provider issues to a covered person for health care services  
2 rendered in the following circumstances, in an amount that  
3 exceeds the covered person's cost-sharing obligation that would  
4 apply for the same health care services if these services had  
5 been provided by a participating provider: 1) emergency  
6 services or emergency ground transportation provided by the  
7 nonparticipating provider; or 2) non-emergency services  
8 rendered by a nonparticipating provider at a participating  
9 facility, where a participating provider is unavailable or a  
10 nonparticipating provider renders unforeseen services or  
11 services without the consent of the covered person; and

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

22 **SECTION 15. EFFECTIVE DATE.**--The effective date of the  
23 provisions of this act is October 1, 2019.