59A-57A-1. Short title.

Sections 1 through 13 [59A-57A-1 to 59A-57A-13 NMSA 1978] of this act may be cited as the "Surprise Billing Protection Act".

History: Laws 2019, ch. 227, § 1.

59A-57A-2. Definitions.

As used in the Surprise Billing Protection Act:

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

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

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

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

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

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

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

H. "covered person" means:

(1) an enrollee, policyholder or subscriber;

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

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

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

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

K. "facility" means an entity providing a health care service, including:

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

(2) an ambulatory surgical center;

(3) a cancer treatment center;

(4) a birth center;

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

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

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

(8) an urgent care center;

(9) a freestanding emergency room; or

(10) any other therapeutic health care setting;

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

M. "health benefits plan" means a policy or agreement entered into or offered or issued by a health insurance carrier 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 any of the following:

(1) an accident-only policy;

(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

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

(6) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act [27-2-1 to 27-2-34 NMSA 1978];

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

(8) a fixed or hospital indemnity policy;

(9) a dental-only policy;

(10) a vision-only policy;

(11) a workers' compensation policy;

(12) an automobile medical payment policy; or

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

N. "health care services":

(1) means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan; and

(2) does not mean ambulance transportation services;

O. "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan

or any other entity that contracts or offers to contract, 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 a health benefit policy or managed health care plan in the state;

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

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

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

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

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

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

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

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

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

Y. "surprise bill":

(1) means a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that

exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

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

(b) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where: 1) a participating provider is unavailable; 2) a nonparticipating provider renders unforeseen services; or 3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered; and

(2) does not mean a bill:

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

(b) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency care or for services rendered pursuant to Subparagraph (b) of Paragraph (1) of this subsection.

History: Laws 2019, ch. 227, § 2.

59A-57A-3. Emergency care; reimbursement; limitation on charges.

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

B. A health insurance carrier shall not require that prior authorization for emergency care be obtained by, or on behalf of, a covered person prior to the point of stabilization of that covered person if a prudent layperson would reasonably believe that the covered person requires emergency care.

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

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

History: Laws 2019, ch. 227, § 3.

59A-57A-4. Non-emergency care; limitation on charges.

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

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

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

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

History: Laws 2019, ch. 227, § 4.