

HOUSE JUDICIARY COMMITTEE SUBSTITUTE FOR  
HOUSE BILL 207

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

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; PROHIBITING  
SURPRISE BILLING AS AN UNFAIR PRACTICE; ESTABLISHING PENALTIES;  
PROVIDING FOR A CONTINGENT REPEAL.

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:

.214309.1

underscoring material = new  
[bracketed material] = delete

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

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

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

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

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

22           E. "copayment" means a cost-sharing method that  
23 requires a covered person to pay a fixed dollar amount when  
24 health care services are received, with the health insurance  
25 carrier paying the balance allowable amount; provided that

.214309.1

1 there may be different copayment requirements for different  
2 types of services under the same health benefits plan;

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

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

11 H. "covered person" means:

12 (1) an enrollee, policyholder or subscriber;

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

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

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

23 J. "emergency care" means a health care procedure,  
24 treatment or service, excluding ambulance transportation  
25 service, which procedure, treatment or service is delivered to

.214309.1

1 a covered person after the sudden onset of what reasonably  
2 appears to be a medical or behavioral health condition that  
3 manifests itself by symptoms of sufficient severity, including  
4 severe pain, that the absence of immediate medical attention,  
5 regardless of eventual diagnosis, could be expected by a  
6 reasonable layperson to result in jeopardy to a person's  
7 physical or mental health or to the health or safety of a fetus  
8 or pregnant person, serious impairment of bodily function,  
9 serious dysfunction of a bodily organ or part or disfigurement  
10 to a person;

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

- 13 (1) a general, special, psychiatric or  
14 rehabilitation hospital;
- 15 (2) an ambulatory surgical center;
- 16 (3) a cancer treatment center;
- 17 (4) a birth center;
- 18 (5) an inpatient, outpatient or residential  
19 drug and alcohol treatment center;
- 20 (6) a laboratory, diagnostic or other  
21 outpatient medical service or testing center;
- 22 (7) a health care provider's office or clinic;
- 23 (8) an urgent care center;
- 24 (9) a freestanding emergency room; or
- 25 (10) any other therapeutic health care

1 setting;

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

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

- 13 (1) an accident-only policy;
- 14 (2) a credit-only policy;
- 15 (3) a long- or short-term care or disability  
16 income policy;
- 17 (4) a specified disease policy;
- 18 (5) coverage provided pursuant to Title 18 of  
19 the federal Social Security Act, as amended;
- 20 (6) coverage provided pursuant to Title 19 of  
21 the federal Social Security Act and the Public Assistance Act;
- 22 (7) a federal TRICARE policy, including a  
23 federal civilian health and medical program of the uniformed  
24 services supplement;
- 25 (8) a fixed indemnity policy;

.214309.1

- 1 (9) a dental-only policy;
- 2 (10) a vision-only policy;
- 3 (11) a workers' compensation policy;
- 4 (12) an automobile medical payment policy; or
- 5 (13) any other policy specified in rules of
- 6 the superintendent;

7 N. "health care services":

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

13 (2) does not mean ambulance transportation  
14 services;

15 O. "health insurance carrier" means an entity  
16 subject to state insurance laws, including a health insurance  
17 company, a health maintenance organization, a hospital and  
18 health service corporation, a provider service network, a  
19 nonprofit health care plan or any other entity that contracts  
20 or offers to contract, or enters into agreements to provide,  
21 deliver, arrange for, pay for or reimburse any costs of health  
22 care services or that provides, offers or administers a health  
23 benefit policy or managed health care plan in the state;

24 P. "hospital" means a facility offering inpatient  
25 health care services, nursing care and overnight care for three

1 or more individuals on a twenty-four-hours-per-day, seven-days-  
2 per-week basis for the diagnosis and treatment of physical,  
3 behavioral or rehabilitative health conditions;

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

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

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

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

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

25 V. "prior authorization" means a pre-service

.214309.1

1 determination made by a health insurance carrier regarding a  
2 covered person's eligibility for services, medical necessity,  
3 benefit coverage and the location or appropriateness of  
4 services, pursuant to the terms of a health benefits plan that  
5 the health insurance carrier offers;

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

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

15 Y. "surprise bill":

16 (1) means a bill that a nonparticipating  
17 provider issues to a covered person for health care services  
18 rendered in the following circumstances, in an amount that  
19 exceeds the covered person's cost-sharing obligation that would  
20 apply for the same health care services if these services had  
21 been provided by a participating provider:

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

24 (b) health care services, that are not  
25 emergency care, rendered by a nonparticipating provider at a



1 participating facility where: 1) a participating provider is  
 2 unavailable; 2) a nonparticipating provider renders unforeseen  
 3 services; or 3) a nonparticipating provider renders services  
 4 for which the covered person has not given specific consent for  
 5 that nonparticipating provider to render the particular  
 6 services rendered; and

7 (2) does not mean a bill:

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

13 (b) received for health care services  
 14 rendered by a nonparticipating provider to a covered person  
 15 whose coverage is provided pursuant to a preferred provider  
 16 plan; provided that the health care services are not provided  
 17 as emergency care."

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

20 "[NEW MATERIAL] EMERGENCY CARE--REIMBURSEMENT--LIMITATION  
 21 ON CHARGES.--

22 A. A health insurance carrier shall reimburse a  
 23 nonparticipating provider for emergency care necessary to  
 24 evaluate and stabilize a covered person if a prudent layperson  
 25 would reasonably believe that emergency care is necessary,

.214309.1

1 regardless of eventual diagnosis.

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

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

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

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

21 "[NEW MATERIAL] NON-EMERGENCY CARE--LIMITATION ON  
22 CHARGES.--

23 A. Other than applicable cost sharing that would  
24 apply if a participating provider had rendered the same  
25 services, a health insurance carrier shall provide

.214309.1

1 reimbursement for and a covered person shall not be liable for  
 2 charges and fees for covered non-emergency care rendered by a  
 3 nonparticipating provider that are delivered when:

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

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

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

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

21 "[NEW MATERIAL] CREDIT AGAINST MAXIMUM OUT-OF-POCKET COST-  
 22 SHARING AMOUNT--COMMUNICATION BY HOSPITALS--ADVANCE  
 23 NOTIFICATION OF CHARGES FOR HEALTH CARE SERVICES.--

24 A. A nonparticipating provider shall not knowingly  
 25 submit a surprise bill to a covered person.

.214309.1

1           B. In accordance with the hearing procedures  
2 established pursuant to the Patient Protection Act, a covered  
3 person may appeal a health insurance carrier's determination  
4 made regarding a surprise bill.

5           C. By July 1, 2020, the department of health shall  
6 require each health facility licensed pursuant to the Public  
7 Health Act to post the following on the health facility's  
8 website in a publicly accessible manner:

9                   (1) the names and hyperlinks for direct access  
10 to the websites of all health benefits plans for which the  
11 hospital has a contract for services;

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

13                           (a) services may be performed in the  
14 hospital by participating providers as well as nonparticipating  
15 providers who may separately bill the patient;

16                           (b) providers that perform health care  
17 services in the hospital may or may not participate in the same  
18 health benefits plans as the hospital; and

19                           (c) prospective patients should contact  
20 their health insurance carriers in advance of receiving  
21 services at that hospital to determine whether the scheduled  
22 health care services provided in that hospital will be covered  
23 at in-network rates;

24                   (3) the rights of covered persons under the  
25 Surprise Billing Protection Act; and

1 (4) instructions for contacting the  
2 superintendent.

3 D. Any communication from a provider, bill  
4 collector or health insurance carrier pertaining to services  
5 provided under circumstances giving rise to a surprise bill  
6 shall clearly state that the covered person is responsible only  
7 for payment of applicable in-network cost-sharing amounts under  
8 the covered person's health benefits plan.

9 E. When a nonparticipating provider under  
10 nonemergency circumstances has advance knowledge that the  
11 nonparticipating provider is not contracted with the covered  
12 person's health insurance carrier, the nonparticipating  
13 provider shall inform the covered person of the  
14 nonparticipating provider's nonparticipating status and advise  
15 the covered person to contact the covered person's health  
16 insurance carrier to discuss the covered person's options."

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

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

20 A. If a covered person pays a nonparticipating  
21 provider more than the in-network cost-sharing amount for  
22 services provided under circumstances giving rise to a surprise  
23 bill, the nonparticipating provider shall refund to the covered  
24 person within forty-five calendar days of receipt of payment  
25 from the health insurance carrier any amount paid in excess of

.214309.1

1 the in-network cost-sharing amount.

2 B. If a nonparticipating provider has not made a  
3 full refund to the covered person of any amount paid in excess  
4 of the in-network cost-sharing amount to the covered person  
5 within forty-five calendar days of receipt, interest shall  
6 accrue at the rate of ten percent per year beginning with the  
7 first calendar day following the forty-five-calendar-day  
8 period.

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

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

18 "[NEW MATERIAL] NONPARTICIPATING PROVIDERS--REBATES AND  
19 INDUCEMENTS--PROHIBITION.--A nonparticipating provider shall  
20 not, either directly or indirectly, knowingly waive, rebate,  
21 give, pay or offer to waive, rebate, give or pay all or part of  
22 a cost-sharing amount owed by a covered person pursuant to the  
23 terms of the covered person's health benefits plan as an  
24 inducement for the covered person to seek a health care service  
25 from that nonparticipating provider. The superintendent may

.214309.1

1 impose fines on providers for unlawful rebates and inducements;  
 2 provided that a provider on which the superintendent intends to  
 3 impose a fine shall be entitled to a hearing in accordance with  
 4 the provisions of Section 59A-4-15 NMSA 1978."

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

7 "[NEW MATERIAL] HEALTH CARE PROVIDER REIMBURSEMENT RATES--  
 8 SURPRISE BILLING.--

9 A. The superintendent shall convene appropriate  
 10 stakeholders and review the reimbursement rate for surprise  
 11 bills biannually to ensure fairness to providers and to  
 12 evaluate the impact on health insurance premiums and health  
 13 benefits plan networks.

14 B. Calculation of the date of health insurance  
 15 carrier receipt of a claim shall align with requirements for  
 16 prompt payment established pursuant to Section 59A-16-21.1 NMSA  
 17 1978.

18 C. A health insurance carrier shall make available  
 19 to providers access to claims status information."

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

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

.214309.1

1 techniques."

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

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

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

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

12 A. shall promulgate rules as may be necessary to  
13 appropriately implement the provisions of the Surprise Billing  
14 Protection Act; and

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

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

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

24 A. group health coverage governed by the provisions  
25 of the Health Care Purchasing Act;

.214309.1



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

4           C. multiple-employer welfare arrangements governed  
5 by the provisions of Section 59A-15-20 NMSA 1978;

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

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

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

15           **SECTION 13.** A new section of the New Mexico Insurance  
16 Code is enacted to read:

17           "[NEW MATERIAL] PROVIDERS--REIMBURSEMENT FOR A SURPRISE  
18 BILL.--

19           A. For services provided under circumstances giving  
20 rise to a surprise bill, a health insurance carrier shall  
21 directly reimburse a nonparticipating provider for care  
22 rendered the usual, customary and reasonable reimbursement rate  
23 for services.

24           B. The usual, customary and reasonable  
25 reimbursement rate shall be calculated using claims data

.214309.1

1 reflecting the allowed amounts paid for claims paid in the 2017  
2 plan year.

3 C. As used in this section, "usual, customary and  
4 reasonable reimbursement rate" means the sixtieth percentile of  
5 the allowed reimbursement rate for the particular health care  
6 service performed by a provider in the same or similar  
7 specialty in the same geographic area, as reported in a  
8 benchmarking database maintained by a nonprofit organization  
9 specified by the superintendent.

10 D. The nonprofit organization shall be conflict-  
11 free and unaffiliated with any stakeholder in the health care  
12 sector."

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

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

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

24 B. It shall be an unfair practice for a health care  
25 provider to submit a surprise bill to a collection agency.

.214309.1

1 C. As used in this section:

2 (1) "covered person" means:

3 (a) an enrollee, policyholder or  
4 subscriber;

5 (b) the enrolled dependent of an  
6 enrollee, policyholder or subscriber; or

7 (c) another individual participating in  
8 a health benefits plan;

9 (2) "emergency care" means a health care  
10 procedure, treatment or service, excluding ambulance  
11 transportation service, which procedure, treatment or service  
12 is delivered to a covered person after the sudden onset of what  
13 reasonably appears to be a medical or behavioral health  
14 condition that manifests itself by symptoms of sufficient  
15 severity, including severe pain, that the absence of immediate  
16 medical attention, regardless of eventual diagnosis, could be  
17 expected by a reasonable layperson to result in jeopardy to a  
18 person's physical or mental health or to the health or safety  
19 of a fetus or pregnant person, serious impairment of bodily  
20 function, serious dysfunction of a bodily organ or part or  
21 disfigurement to a person;

22 (3) "facility" means an entity providing a  
23 health care service, including:

24 (a) a general, special, psychiatric or  
25 rehabilitation hospital;

.214309.1

- 1 (b) an ambulatory surgical center;
- 2 (c) a cancer treatment center;
- 3 (d) a birth center;
- 4 (e) an inpatient, outpatient or
- 5 residential drug and alcohol treatment center;
- 6 (f) a laboratory, diagnostic or other
- 7 outpatient medical service or testing center;
- 8 (g) a health care provider's office or
- 9 clinic;
- 10 (h) an urgent care center;
- 11 (i) a freestanding emergency room; or
- 12 (j) any other therapeutic health care
- 13 setting;

14 (4) "freestanding emergency room" means a  
15 facility licensed by the department of health that is separate  
16 from an acute care hospital and that provides twenty-four-hour  
17 emergency care to patients at the same level of care that a  
18 hospital-based emergency room delivers;

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

- 24 (a) an accident-only policy;
- 25 (b) a credit-only policy;

- 1 (c) a long- or short-term care or  
2 disability income policy;
- 3 (d) a specified disease policy;
- 4 (e) coverage provided pursuant to Title  
5 18 of the federal Social Security Act, as amended;
- 6 (f) coverage provided pursuant to Title  
7 19 of the federal Social Security Act and the Public Assistance  
8 Act;
- 9 (g) a federal TRICARE policy, including  
10 a federal civilian health and medical program of the uniformed  
11 services supplement;
- 12 (h) a fixed indemnity policy;
- 13 (i) a dental-only policy;
- 14 (j) a vision-only policy;
- 15 (k) a workers' compensation policy;
- 16 (l) an automobile medical payment  
17 policy; or
- 18 (m) any other policy specified in rules  
19 of the superintendent;
- 20 (6) "health care services":
- 21 (a) means any service, supply or  
22 procedure for the diagnosis, prevention, treatment, cure or  
23 relief of a health condition, illness, injury or other disease,  
24 including physical or behavioral health services, to the extent  
25 offered by a health benefits plan; and

.214309.1

1 (b) does not mean ambulance  
2 transportation services;

3 (7) "health insurance carrier" means an entity  
4 subject to state insurance laws, including a health insurance  
5 company, a health maintenance organization, a hospital and  
6 health service corporation, a provider service network, a  
7 nonprofit health care plan or any other entity that contracts  
8 or offers to contract, or enters into agreements to provide,  
9 deliver, arrange for, pay for or reimburse any costs of health  
10 care services or that provides, offers or administers a health  
11 benefit policy or managed health care plan in the state;

12 (8) "hospital" means a facility offering  
13 inpatient health care services, nursing care and overnight care  
14 for three or more individuals on a twenty-four-hours-per-day,  
15 seven-days-per-week basis for the diagnosis and treatment of  
16 physical, behavioral or rehabilitative health conditions;

17 (9) "nonparticipating provider" means a  
18 provider who is not a participating provider;

19 (10) "participating provider" means a provider  
20 or facility that, under express contract with a health  
21 insurance carrier or with a health insurance carrier's  
22 contractor or subcontractor, has agreed to provide health care  
23 services to covered persons, with an expectation of receiving  
24 payment directly or indirectly from the health insurance  
25 carrier, subject to cost sharing;

.214309.1

1 (11) "prior authorization" means a pre-service  
2 determination made by a health insurance carrier regarding a  
3 covered person's eligibility for health care services, medical  
4 necessity, benefit coverage and the location or appropriateness  
5 of services, pursuant to the terms of a health benefits plan  
6 that the health insurance carrier offers;

7 (12) "provider" means a health care  
8 professional, hospital or other facility licensed to furnish  
9 health care services; and

10 (13) "surprise bill":

11 (a) means a bill that a nonparticipating  
12 provider issues to a covered person for health care services  
13 rendered in the following circumstances, in an amount that  
14 exceeds the covered person's cost-sharing obligation that would  
15 apply for the same health care services if these services had  
16 been provided by a participating provider: 1) emergency care  
17 provided by the nonparticipating provider; or 2) health care  
18 services, that are not emergency care, rendered by a  
19 nonparticipating provider at a participating facility where a:  
20 participating provider is unavailable; a nonparticipating  
21 provider renders unforeseen services; or a nonparticipating  
22 provider renders services for which the covered person has not  
23 given specific consent for that nonparticipating provider to  
24 render the particular services rendered; and

25 (b) does not mean a bill: 1) for health

.214309.1

1 care services received by a covered person when a participating  
2 provider was available to render the health care services and  
3 the covered person knowingly elected to obtain the services  
4 from a nonparticipating provider without prior authorization;  
5 or 2) received for health care services rendered by a  
6 nonparticipating provider to a covered person whose coverage is  
7 provided pursuant to a preferred provider plan; provided that  
8 the health care services are not provided as emergency care."

9 SECTION 15. A new section of Chapter 59A, Article 16 NMSA  
10 1978 is enacted to read:

11 "[NEW MATERIAL] EMPLOYEE RETIREMENT INCOME SECURITY ACT OF  
12 1974 PLAN EXEMPT FROM STATE JURISDICTION--OPT-IN.--A large  
13 group or self-insured health plan offered in accordance with  
14 the provisions of the federal Employee Retirement Income  
15 Security Act of 1974 that is exempt from regulation under the  
16 New Mexico Insurance Code may adopt the provisions of the  
17 Surprise Billing Protection Act. The office of superintendent  
18 of insurance shall post on its website in a manner that is  
19 accessible to the public, information on which exempt large  
20 group and self-insurance health plans follow the provisions of  
21 the Surprise Billing Protection Act."

22 SECTION 16. DELAYED REPEAL.--Section 13 of this act is  
23 repealed effective July 1, 2023.

24 SECTION 17. EFFECTIVE DATE.--The effective date of the  
25 provisions of this act is January 1, 2020.