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

SPONSOR SCORC **ORIGINAL DATE** 1/25/19 **LAST UPDATED** 3/14/19 **HB**

SHORT TITLE Surprise Billing Protection Act **SB** 337/SCORCS/aSJC/ aHHHC

ANALYST Chilton/Daly

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Indeterminate; possible moderate cost saving	Indeterminate; possible moderate cost saving	Indeterminate; possible moderate cost saving	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases) See Fiscal Impact, below.

Identical to House Bill CS/CS/207/HJC/HFl

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
Department of Health (DOH)

SUMMARY

Synopsis of HHHC Amendment

The House Health and Human Services Committee Amendment to Senate Bill 337 as twice amended removes one type of bill from the definition of "surprise bill"—a bill for health care services that are not emergency care rendered by a nonparticipating provider at a participating facility under certain defined conditions.

Synopsis of SJC Amendment

The Senate Judiciary Committee Amendment makes the following changes:

1) It specifies further that the stakeholders who should be consulted regarding reviewing the reimbursement rate for surprise bills should include rural providers, insurers, and consumer advocates."
2) OSI is no longer required to promulgate rules regarding implementing the provisions of the act.
3) Health insurers would not be required to specify the proportion of claims but could be

required to report on changes in percent of claims paid as emergencies.

4) A provision is added that the lowest reimbursement for a service to a nonparticipating provider would be at 150 percent of the Medicare reimbursement for the same service.

Synopsis of Original Bill

Surprise billing occurs when a patient goes to a clinic or hospital, often to an emergency department within the health insurance plan's network, and then receives a bill from a medical provider working in those in-network locations but the provider is not in network. This usually occurs because the hospital or clinic contracts for services from a provider who has not been admitted to the health insurer's network. Senate Bill 337 would regulate the practice, with the aim of preventing all or most surprise billing.

Summary of the major provisions of the bill:

Bill section	Summary
1	Short title, as above.
2	Definitions as used in the bill, including definition of "surprise billing" as above, specifically excepting from the definition those occasions when a patient chose a nonparticipating provider over an available participating provider or when the care provided is not provided in an emergency situation. "Health benefits plan" is defined as a policy issued by an insurer to pay for health services but does not include short-term, limited plans, fixed or hospital indemnity policies, Medicaid, or Medicare. "Health care services" is defined to include all types of medical care, but specifically excepts ambulance services.
3	In what a "prudent layperson" would consider an emergency, copayments, co-insurance, or other limitations of benefits (together described as "cost-sharing)" could not be applied to an out-of-provider's bill to a greater extent than for participating provider's.
4	Beyond cost-sharing that would have applied within an insurer's network, nonemergency care would not be subject to additional cost-sharing if one the following applied: 1) The patient at an in-network facility does not have the chance to choose an in-network provider or 2) "Medically necessary" care, as determined by a patient's provider, is not available in network.
5	The bill prohibits nonparticipating providers from knowingly submitting a surprise bill to a covered person. This section also applies the Insurance Code's Patient Protection Act and its grievance and appeals procedures for consumers who have a dispute with their insurance company about whether the bill is a surprise bill. It creates notice requirements for hospitals to post information about their network participation on their websites by July 1, 2020, in keeping with DOH's regulations. This section also addresses the issue of provider and carrier consumer communication about surprise bills. Written communications (other than receipts) from providers or health insurance carriers to patients regarding surprise bills must clearly state that the patient is responsible only for paying in-network cost-sharing amounts.
6	Nonparticipating providers who have received payment from a patient must refund to the patient any amount greater than the cost-sharing that would have applied had the provider been in-network. The payment would be made within 45 days of receipt from the insurer, or interest would also be paid at the same rate as on liability for clean claims. Patients could appeal to OSI, which is

	required to set up an appeals process, to seek repayment of any amount they had paid in excess of an in-network cost-sharing amount.
7	Nonparticipating providers could not offer inducements to covered patients to use their services.
8	OSI must, convening appropriate stakeholders, review the reimbursements for surprise bills made under this act every twelve months, estimating the effect of these regulations on health insurance premiums and health benefits plan networks. Claim date receipt is to be calculated in the manner codified in "Health plan requirements," Section 59A-16.21.1 NMSA 1978. Providers must be given access to claims status information by insurers.
9	Insurance carriers could still use "reasonable health care cost management techniques."
10	Prohibits private causes of action except as otherwise outlined in the act
11	OSI must promulgate rules to implement the act and could require insurers to divulge the percentage of claims the insurer pays to non-participating providers.
12	Applies the legislation to fully insured and individual group health insurance plans, public employee plans issued under the Health Care Purchasing Act, and HMO and nonprofit plans
13	Sets reimbursement rates for surprise bills. Payment to nonparticipating providers must be made through determination of a "surprise bill reimbursement rate" determined as the 60th percentile of allowed commercial reimbursement rates for the same service in the same geographical are according to a conflict-free benchmarking organization selected by OSI in consultation with health care stakeholders.
14	Providers shall not knowingly submit a surprise bill in an amount greater than the cost-sharing amount that would have been assessed for care provided by an in-network provider. It is to be considered an unfair trade practice to submit a surprise bill to a collection agency.
15	Section 13 of the act is repealed as of July 1, 2023.
16	Sets the effective date of the act as January 1, 2020.

FISCAL IMPLICATIONS

The Office of the Superintendent would be tasked with making regulations and enforcing the provisions of this act and in analyzing and reporting on its effects on health insurance premiums. OSI indicates the personnel costs of doing so would probably be offset by a decrease in personnel time required to investigate consumer complaints about surprise billing. OSI's analysis of these costs and benefits follows:

> New Mexico Superintendent of Insurance's Managed Care Division handles more complaints about surprise billing than any other type of complaint. The Managed Care Division estimates that it handles approximately 200 surprise bill complaints a year. This number has grown in recent years. This legislation may eventually lessen the number of complaints or turn around the trend in volume increase of complaints related to surprise billing. As a result, the legislation may curb a trend that would ultimately result in OSI needing additional staff to handle surprise billing complaints. As written, the legislation's impact on OSI staffing needs is minimal.
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> This legislation also may impact uncompensated care rates in New Mexico. By shifting

responsibility for payment of surprise medical bills from consumers onto insurers, providers may see more compensation of their services, lessening the need for state and local fiscal support.

SIGNIFICANT ISSUES

In an article in the medical journal, *New England Journal of Medicine*, public health economists Zack Cooper and Fiona Martin report that, in their large study of emergency room visits, 22 percent of emergency room visits to in-network emergency facilities involved an out-of-network provider, giving rise to surprise bills. The president, Rebecca Parker, of the American College of Emergency Physicians disputed this study and its conclusions. The Cooper-Martin study and the exchange between those researchers and Dr. Parker are available as attachments one and two to this analysis.

DOH makes note of publications on the effects of surprise billing and their amelioration through state legislation:

In its June 2017 issue brief titled *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*, the Commonwealth Fund noted "Privately insured consumers expect that if they pay premiums and use in-network providers, their insurer will cover the cost of medically necessary care beyond their cost-sharing. However, when obtaining care at emergency departments and in-network hospitals, patients treated by an out-of-network provider may receive an unexpected "balance bill" for an amount beyond what the insurer paid. With no explicit federal protections against balance billing, some states have stepped in to protect consumers from this costly and confusing practice" (www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer?redirect_source=/publications/issue-briefs/2017/jun/balance-billing-consumer-protections-states). The issue brief stated that, at that time, only six states incorporated a comprehensive approach for protecting consumers by:

- extending protections to both emergency departments and in-network hospital settings;
- applying laws to both HMOs and preferred-provider organizations (PPOs);
- protecting consumers both by holding them harmless from extra provider charges;
- prohibiting providers from balance billing; and,
- adopting adequate payment standards or dispute resolution processes to resolve payment disputes between providers and insurers.

The issue brief noted that New York, one of the latest states to have implemented a comprehensive approach, had reported that the law was "highly effective" in establishing consumer protections, although some gaps remained.

The Commonwealth Fund issue brief also found that another 15 states, including New Mexico, offered balance billing protections with some significant limitations. Of note, the brief indicated that NM's protections only applied to emergency departments but not to non-emergency care in network hospitals. While New Mexico provided "hold harmless" protection to consumers requiring that insurers pay providers their billed charges or some lower amount that is acceptable to the provider, there was no "provider prohibition" protection such that out-of-network providers could not bill insured patients beyond any allowed cost-sharing amounts. New Mexico's provision did apply to both

> HMO and preferred provider organization (PPO) managed care plans. Regarding method for payment, New Mexico did not stipulate a payment standard or dispute resolution process.
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> The provisions of SB337 would fill some of the gaps in New Mexico's approach to balance-billing protections. This would include extending protections to include non-emergency care in network hospitals. By creating provisions related to providers, including that "a nonparticipating provider shall not knowingly submit a surprise bill to a covered person," SB337 would also establish previously absent "provider prohibition" protections for New Mexico consumers. SB337 would provide payment standards, which would be subject to repeal upon certification by the superintendent of insurance that it has adopted and promulgated rules to establish benchmarks for health insurance carriers to follow when making reimbursement to health care providers for services provided under circumstances that give rise to surprise billing.

OSI makes note of a study commissioned by that office,

> A survey commissioned by OSI and published in 2017 found that twenty percent of privately insured New Mexicans had received a surprise medical bill. This number is higher for individuals who had had surgery (36 percent) or who had visited the ER (55 percent). Approximately 31 percent of these consumers felt sufficiently powerless in these circumstances that they took no action on these bills.
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> This comports with national findings, including a recent New England Journal of Medicine study analyzed out-of-network billing for emergency services. Nationally, 22 percent of emergency department visits at in-network facilities involved out-of-network physicians. A 2015 Consumer's Union survey found that in the past two years, 30 V of privately insured Americans received a surprise medical bill (a medical bill where the health plan paid less than expected). Among just individuals who had received hospital care, the number rose to 37 percent.

OSI states further that OSI's current authority to protect consumers against surprise medical bills is only applicable to emergency care. The Patient Protection Act requires carriers to hold consumers harmless for out-of-network emergency care. This statute does not address OSI's authority to prohibit providers from submitting surprise bills to patients. It also does not address nonemergent care.

DUPLICATION

Duplicate of Senate Bill 337 as substituted by the Senate Corporations and Transportation Committee.

TECHNICAL ISSUES

"Reasonable health care management techniques" as allowed under Section 9 are not defined.

LAC/sb