

1 SENATE BILL 17

2 **56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023**

3 INTRODUCED BY

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10 AN ACT

11 RELATING TO INSURANCE; ENACTING NEW SECTIONS OF THE HEALTH CARE
12 PURCHASING ACT AND THE SHORT-TERM HEALTH PLAN AND EXCEPTED
13 BENEFIT ACT TO ADDRESS ISSUES RELATED TO THE PRIOR
14 AUTHORIZATION PROCESS, COLLECTION OF OVERPAYMENTS, ASSIGNMENT
15 OF BENEFITS, ACCEPTABLE METHODS OF PAYMENT AND NETWORK LEASING;
16 ENACTING A NEW SECTION OF THE SHORT-TERM HEALTH PLAN AND
17 EXCEPTED BENEFIT ACT TO ADDRESS METHODS FOR CALCULATING RATES
18 AND MEDICAL LOSS RATIO.

19
20 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

21 SECTION 1. A new section of the Health Care Purchasing
22 Act is enacted to read:

23 "[NEW MATERIAL] DENTAL COVERAGE--PRIOR AUTHORIZATION.--

24 A. For purposes of this section, "prior
25 authorization" means a communication indicating whether a

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1 service is covered and reimbursable at a specific amount,
2 subject to applicable coinsurance and deductibles, and issued
3 in response to a request submitted by a provider using a format
4 proscribed by a dental plan.

5 B. Group coverage, including any form of self-
6 insurance, offered, issued or renewed under the Health Care
7 Purchasing Act that offers a dental plan shall provide a prior
8 authorization upon the submission of a properly formatted
9 request from the insured.

10 C. Group coverage, including any form of self-
11 insurance, offered, issued or renewed under the Health Care
12 Purchasing Act that offers a dental plan shall not deny any
13 claim subsequently submitted for services included in a prior
14 authorization unless one of the following circumstances applies
15 for each service denied:

16 (1) benefit limitations, including annual
17 maximums or frequency limitations, not applicable at the time
18 of the prior authorization, are reached due to the insured's
19 utilization subsequent to issuance of the prior authorization;

20 (2) the documentation submitted for the claim
21 clearly fails to support the claim as originally authorized;

22 (3) subsequent to the issuance of a prior
23 authorization, new services are provided to the insured or a
24 change in the covered person's condition occurs that would
25 cause prior-authorized services to no longer be medically

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1 necessary, based on prevailing standards of care; or

2 (4) denial of the claim was due to one of the
3 following reasons:

4 (a) another entity is responsible for
5 payment;

6 (b) the provider has already been paid
7 for the services identified on the claim;

8 (c) the claim submitted was fraudulent;

9 (d) the prior authorization was based on
10 erroneous information provided to the dental plan by the
11 provider, the insured or other person; or

12 (e) the insured was not eligible for the
13 service on the date it was provided and the provider did not
14 know, or with the exercise of reasonable care, could not have
15 known the insured's eligibility status."

16 SECTION 2. A new section of the Health Care Purchasing
17 Act is enacted to read:

18 "[NEW MATERIAL] DENTAL COVERAGE--ASSIGNMENT OF BENEFITS.--

19 A. Group coverage, including any form of self-
20 insurance, offered, issued or renewed under the Health Care
21 Purchasing Act that offers a dental plan shall provide for the
22 direct payment of covered benefits to a provider, specified by
23 the insured, regardless of the provider's network or
24 contractual status with the dental plan.

25 B. A dental plan shall provide for the direct

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1 payment of covered benefits to a provider, specified by the
2 insured, by including on its claim forms an:

3 (1) option for the assignment of benefits from
4 the insured to the provider; and

5 (2) an attestation to be completed by the
6 insured."

7 SECTION 3. A new section of the Health Care Purchasing
8 Act is enacted to read:

9 "[NEW MATERIAL] DENTAL COVERAGE--ERRONEOUSLY PAID CLAIMS--
10 RESTRICTIONS ON RECOVERY.--

11 A. Group coverage, including any form of self-
12 insurance, offered, issued or renewed under the Health Care
13 Purchasing Act that offers a dental plan shall establish
14 policies and procedures for payment recovery, including
15 providing:

16 (1) notice to the provider that identifies the
17 error made in the processing or payment of the claim;

18 (2) an explanation of the recovery being
19 sought; and

20 (3) an opportunity for the provider to
21 challenge the recovery being sought.

22 B. Group coverage, including any form of self-
23 insurance, offered, issued or renewed under the Health Care
24 Purchasing Act that offers a dental plan shall not initiate
25 payment recovery procedures more than twenty-four months after

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1 the original payment for a claim was made.

2 C. Group coverage, including any form of self-
3 insurance, offered, issued or renewed under the Health Care
4 Purchasing Act that offers a dental plan shall not attempt to
5 recover an erroneously paid claim by withholding or reducing
6 payment for a different claim.

7 D. The provisions of this section shall not apply
8 to duplicate payments."

9 SECTION 4. A new section of the Health Care Purchasing
10 Act is enacted to read:

11 "[NEW MATERIAL] DENTAL COVERAGE--METHODS OF PAYMENT.--

12 A. For purposes of this section, "credit card
13 payment" means a type of electronic funds transfer whereby:

14 (1) an insurer issues a single-use series of
15 numbers associated with the payment of services rendered by the
16 provider and chargeable to a predetermined amount; and

17 (2) the provider is responsible for processing
18 the payment by using a credit card terminal or internet portal.

19 B. Group coverage, including any form of self-
20 insurance, offered, issued or renewed under the Health Care
21 Purchasing Act that offers a dental plan shall not place
22 restrictions on a provider regarding acceptable methods of
23 payment, including designating credit card payments as the only
24 acceptable form of payment.

25 C. When transmitting a payment to a provider using

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1 an electronic funds transfer, other than one made through the
2 automated clearinghouse network, an insurer:

3 (1) shall not charge a fee to the provider
4 solely to transmit a payment without the provider's consent;

5 (2) shall notify the provider of any other
6 fees associated with transmitting a payment; and

7 (3) shall provide a provider with a fee-free
8 method of transmitting a payment and provide instructions for
9 utilizing the method."

10 SECTION 5. A new section of the Health Care Purchasing
11 Act is enacted to read:

12 "[NEW MATERIAL] DENTAL COVERAGE--PROVIDER NETWORK
13 LEASING.--

14 A. For purposes of this section:

15 (1) "contracting entity" means any person or
16 entity that enters into direct contracts with a provider for
17 the delivery of services in the ordinary course of business;

18 (2) "provider" means a person acting within
19 the scope of licensure to provide dental services or supplies;

20 (3) "provider network contract" means a
21 contract between a contracting entity and a provider specifying
22 the rights and responsibilities of the contracting entity and
23 providing for the delivery of and payment for services to the
24 insured; and

25 (4) "third party" means a person or entity

1 that enters into a contract with a contracting entity or with
2 another third party to gain access to the services or
3 contractual discounts of a provider network contract.

4 B. A contracting entity shall not grant a third
5 party access to a provider network contract, a provider's
6 services or discounts provided pursuant to a provider network
7 contract unless:

8 (1) the provider network contract states that
9 the contracting entity may enter into an agreement with a third
10 party, allowing a third party to obtain the insurer's rights
11 and responsibilities as though the third party were the
12 contracting entity;

13 (2) the third party accessing the provider
14 network contract agrees to comply with all of the terms of the
15 provider network contract; and

16 (3) the contracting entity:

17 (a) identifies all third parties with
18 which it contracts in a list on its website that is updated
19 every ninety days;

20 (b) notifies a provider that a new third
21 party is planning to lease or purchase the provider network
22 contract, at least thirty business days before the lease or
23 purchase takes effect;

24 (c) provides an opportunity for the
25 provider to opt out of the provider network contract within

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1 fifteen business days of receiving notice pursuant to
2 Subparagraph (b) of this paragraph;

3 (d) requires the third party to identify
4 the source of the discount on all remittances or explanation of
5 benefits under which the discount is taken; and

6 (e) makes available a copy of the
7 provider network contract relied upon in the adjudication of a
8 claim to a provider within thirty days of the provider's
9 request.

10 C. A third party's right to a provider's discounted
11 rate shall cease upon the termination date of the provider
12 network contract."

13 SECTION 6. Section 59A-23G-1 NMSA 1978 (being Laws 2019,
14 Chapter 235, Section 1) is amended to read:

15 "59A-23G-1. SHORT TITLE.--~~[Sections 1 through 6 of this~~
16 ~~act]~~ Chapter 59A, Article 23G NMSA 1978 may be cited as the
17 "Short-Term Health Plan and Excepted Benefit Act"."

18 SECTION 7. A new section of the Short-Term Health Plan
19 and Excepted Benefit Act is enacted to read:

20 "[NEW MATERIAL] DENTAL PLAN--PRIOR AUTHORIZATION.--

21 A. For purposes of this section, "prior
22 authorization" means a communication indicating whether a
23 service is covered and reimbursable at a specific amount,
24 subject to applicable coinsurance and deductibles, and issued
25 in response to a request submitted by a provider using a format

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1 proscribed by a dental plan.

2 B. A dental plan shall provide a prior
3 authorization upon the submission of a properly formatted
4 request from a covered person.

5 C. A dental plan shall not deny any claim
6 subsequently submitted for services included in a prior
7 authorization unless one of the following circumstances applies
8 for each service denied:

9 (1) benefit limitations, including annual
10 maximums or frequency limitations, not applicable at the time
11 of the prior authorization, are reached due to the covered
12 person's utilization subsequent to issuance of the prior
13 authorization;

14 (2) the documentation submitted for the claim
15 clearly fails to support the claim as originally authorized;

16 (3) subsequent to the issuance of a prior
17 authorization, new services are provided to the covered person
18 or a change in the covered person's condition occurs that would
19 cause prior-authorized services to no longer be medically
20 necessary, based on prevailing standards of care; or

21 (4) denial of the claim was due to one of the
22 following reasons:

23 (a) another entity is responsible for
24 payment;

25 (b) the provider has already been paid

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- 1 for the services identified on the claim;
- 2 (c) the claim submitted was fraudulent;
- 3 (d) the prior authorization was based on
- 4 erroneous information provided to the dental plan by the
- 5 provider, the covered person or other person; or
- 6 (e) the covered person was not eligible
- 7 for the service on the date it was provided and the provider
- 8 did not know, or with the exercise of reasonable care, could
- 9 not have known the covered person's eligibility status."

10 SECTION 8. A new section of the Short-Term Health Plan
11 and Excepted Benefit Act is enacted to read:

12 "[NEW MATERIAL] DENTAL PLAN--ASSIGNMENT OF BENEFITS.--

13 A. A dental plan shall provide for the direct
14 payment of covered benefits to a provider, specified by a
15 covered person, regardless of the provider's network or
16 contractual status with the dental plan.

17 B. A dental plan shall provide for the direct
18 payment of covered benefits to a provider, specified by a
19 covered person, by including on its claim forms an:

20 (1) option for the assignment of benefits from
21 the covered person to the provider; and

22 (2) an attestation to be completed by the
23 covered person."

24 SECTION 9. A new section of the Short-Term Health Plan
25 and Excepted Benefit Act is enacted to read:

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1 "[NEW MATERIAL] DENTAL PLAN--ERRONEOUSLY PAID CLAIMS--
2 RESTRICTIONS ON RECOVERY.--

3 A. A dental plan shall establish policies and
4 procedures for payment recovery, including providing:

5 (1) notice to the provider that identifies the
6 error made in the processing or payment of the claim;

7 (2) an explanation of the recovery being
8 sought; and

9 (3) an opportunity for the provider to
10 challenge the recovery being sought.

11 B. A dental plan shall not initiate payment
12 recovery procedures more than twenty-four months after the
13 original payment for a claim was made.

14 C. A dental plan shall not attempt to recover an
15 erroneously paid claim by withholding or reducing payment for a
16 different claim.

17 D. The provisions of this section shall not apply
18 to duplicate payments."

19 SECTION 10. A new section of the Short-Term Health Plan
20 and Excepted Benefit Act is enacted to read:

21 "[NEW MATERIAL] DENTAL PLAN--METHODS OF PAYMENT.--

22 A. For purposes of this section, "credit card
23 payment" means a type of electronic funds transfer whereby:

24 (1) a health insurance carrier issues a
25 single-use series of numbers associated with the payment of

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1 services rendered by the provider and chargeable to a
2 predetermined amount; and

3 (2) the provider is responsible for processing
4 the payment by using a credit card terminal or internet portal.

5 B. A health insurance carrier shall not place
6 restrictions on a provider regarding acceptable methods of
7 payment, including designating credit card payments as the only
8 acceptable form of payment.

9 C. When transmitting a payment to a provider using
10 an electronic funds transfer, other than one made through the
11 automated clearinghouse network, a health insurance carrier:

12 (1) shall not charge a fee to the provider
13 solely to transmit a payment without the provider's consent;

14 (2) shall notify the provider of any other
15 fees associated with transmitting a payment; and

16 (3) shall provide a provider with a fee-free
17 method of transmitting a payment and provide instructions for
18 utilizing the method."

19 SECTION 11. A new section of the Short-Term Health Plan
20 and Excepted Benefit Act is enacted to read:

21 "[NEW MATERIAL] DENTAL PLAN--PROVIDER NETWORK LEASING.--

22 A. For purposes of this section:

23 (1) "contracting entity" means any person or
24 entity that enters into direct contracts with a provider for
25 the delivery of services in the ordinary course of business;

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1 (2) "provider" means a person acting within
2 the scope of licensure to provide dental services or supplies;

3 (3) "provider network contract" means a
4 contract between a contracting entity and a provider specifying
5 the rights and responsibilities of the contracting entity and
6 providing for the delivery of and payment for services to
7 covered persons; and

8 (4) "third party" means a person or entity
9 that enters into a contract with a contracting entity or with
10 another third party to gain access to the services or
11 contractual discounts of a provider network contract.

12 B. A contracting entity shall not grant a third
13 party access to a provider network contract, a provider's
14 services or discounts provided pursuant to a provider network
15 contract unless:

16 (1) the provider network contract states that
17 the contracting entity may enter into an agreement with a third
18 party, allowing a third party to obtain the health insurance
19 carrier's rights and responsibilities as though the third party
20 were the contracting entity;

21 (2) the third party accessing the provider
22 network contract agrees to comply with all of the terms of the
23 provider network contract; and

24 (3) the contracting entity:

25 (a) identifies all third parties with

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1 which it contracts in a list on its website that is updated
2 every ninety days;

3 (b) notifies a provider that a new third
4 party is planning to lease or purchase the provider network
5 contract at least thirty business days before the lease or
6 purchase takes effect;

7 (c) provides an opportunity for the
8 provider to opt out of the provider network contract within
9 fifteen business days of receiving notice pursuant to
10 Subparagraph (b) of this paragraph;

11 (d) requires the third party to identify
12 the source of the discount on all remittances or explanation of
13 benefits under which the discount is taken; and

14 (e) makes available a copy of the
15 provider network contract relied upon in the adjudication of a
16 claim to a provider within thirty days of the provider's
17 request.

18 C. A third party's right to a provider's discounted
19 rate shall cease upon the termination date of the provider
20 network contract."

21 SECTION 12. A new section of the Short-Term Health Plan
22 and Excepted Benefit Act is enacted to read:

23 "[NEW MATERIAL] DENTAL PLAN--RATES.--

24 A. The superintendent shall disapprove:

25 (1) proposed changes to a dental plan's base

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1 rates that are excessive, inadequate or unreasonable in
2 relation to the benefits charged; and

3 (2) changes to group rating factors that are
4 discriminatory or not actuarially sound.

5 B. The superintendent may presumptively disapprove
6 rates as excessive if:

7 (1) proposed changes to a dental plan's base
8 rates are excessive, inadequate or unreasonable in relation to
9 the benefits charged; and

10 (2) changes to group rating factors are
11 discriminatory or not actuarially sound.

12 C. The superintendent may presumptively disapprove
13 rates as excessive if:

14 (1) the proposed base rate change represents
15 an increase greater than the most recent calendar year's
16 percentage increase in the dental services consumer price
17 index;

18 (2) a health insurance carrier's reported
19 contribution to surplus exceeds one and nine-tenths percent; or

20 (3) the aggregate medical loss ratio for all
21 plans offered by the health insurance carrier is less than the
22 applicable percentage set for in Paragraph (2) of this
23 subsection."

24 **SECTION 13.** A new section of the Short-Term Health Plan
25 and Excepted Benefit Act is enacted to read:

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"[NEW MATERIAL] DENTAL PLAN--MEDICAL LOSS RATIO.--The superintendent shall adopt and promulgate rules to establish standards for medical loss ratios for dental plans. Rules relating to ratios shall be based on generally recognized and current actuarial standards; provided that for:

- A. large group plans, the medical loss ratio shall be established at eighty-five percent or higher;
- B. small group plans, the medical loss ratio shall be established at eighty percent or higher; and
- C. individual plans, the medical loss ratio shall be established at sixty-five percent or higher."

SECTION 14. APPLICABILITY.--The provisions of this act apply to dental plans issued for delivery or renewed in this state on or after January 1, 2024.