SENATE BILL 17

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

INTRODUCED BY

Peter Wirth and Bill Tallman and Tara L. Lujan

AN ACT

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

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

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

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

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

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

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

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

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

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

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

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necessary, based on prevailing standards of care; or

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

(a) another entity is responsible for payment;

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

(c) the claim submitted was fraudulent;

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

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

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

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

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

B. A dental plan shall provide for the direct

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

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

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

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

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

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

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

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

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

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

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the original payment for a claim was made.

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

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

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

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

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

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

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

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

C. When transmitting a payment to a provider using

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

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

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

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

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

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

A. For purposes of this section:

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

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

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

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

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

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

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

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

(3) the contracting entity:

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

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

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

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

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

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

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

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

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

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

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

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

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proscribed by a dental plan.

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

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

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

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

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

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

(a) another entity is responsible for payment;

(b) the provider has already been paid

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for the services identified on the claim;

(c) the claim submitted was fraudulent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. For purposes of this section:

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

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

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

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

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

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

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

(3) the contracting entity:

(a) identifies all third parties with

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

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

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

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

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

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

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

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

A. The superintendent shall disapprove:

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

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

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

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

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

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

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

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

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

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

SECTION 13. A new section of the Short-Term Health Plan 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.

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