HOUSE BILL 313

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

Deborah A. Armstrong

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 A HEALTH BENEFITS PLAN; PROVIDING FOR DISPUTE RESOLUTION; ESTABLISHING PENALTIES.

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.--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:

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

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A. "ambulance service" means any government or transportation service designated and used or intended to be used for the transportation of sick or injured persons;

B. "balance billing" means the practice when a provider bills an insured for the difference between the provider's charge and the health carrier's allowed amount;

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

D. "coinsurance" means the percentage of the costs of a covered service that a covered person pays after the covered person pays the covered person's deductible;

E. "confidential proprietary information" means commercial or financial information:

(1) that is privileged or confidential; and

(2) the disclosure of which would cause substantial harm to the competitive position of the person that submitted the information;

F. "confidential record" means a record containing nonpublic personal health information, trade secrets or confidential proprietary information and copies thereof that are in the possession or control of the superintendent, any resolution organization or any other person that is produced by, obtained by or disclosed to any of these persons in the course of a dispute resolution process made pursuant to the Surprise Billing Protection Act;

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G. "copayment" means a fixed amount a covered person pays for a health care service either before or after the deductible is paid;

H. "cost-sharing" means a copayment, coinsurance, 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 the health care plan;

I. "covered benefits" means the specific health services provided under a health benefits plan;

J. "covered person" means an insured, policyholder, subscriber, enrollee or other individual participating in a health benefit plan, as a primary insured or as a dependent;

K. "covered service" means a health care service reimbursable by a health carrier pursuant to a health benefits plan;

L. "deductible" means a fixed dollar amount that a covered person may be required to pay during a benefit period before the health benefits plan begins payment for covered benefits; plans may have both individual and family deductibles and separate deductibles for specific services. Plans may offer first-dollar services without requiring a covered person to first meet the deductible;

M. "emergency medical condition" means a physical, mental or behavioral health condition that manifests itself by

acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson in that circumstance, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(1) placing the individual's physical, mental or behavioral health or, with respect to a pregnant woman, the woman or her fetus's health in serious jeopardy;

(2) serious impairment of bodily function;

(3) serious impairment of any bodily organ or part;

(4) a condition described in other state or federal law, as applicable; or

(5) with respect to a pregnant woman who is having contractions, that:

(a) there is inadequate time to effect a safe transfer to another facility before delivery; or

(b) transfer to another facility may pose a threat to the health or safety of the woman or fetus;

N. "emergency services" means, with respect to an emergency medical condition:

(1) a medical or mental health screening examination that is within the capacity of the emergency department of a facility, including ancillary services routinely available to the emergency department to evaluate the

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emergency medical condition;

(2) any further medical or mental health examination and treatment to the extent that it is within the capabilities of the staff and facilities available at the hospital to stabilize the patient; and

(3) ambulance services used to transport an individual experiencing an emergency medical condition, including services provided by emergency medical technicians;

O. "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; or

(9) any other therapeutic health care setting;

P. "health benefits plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or

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reimburse any of the costs of health care services. For purposes of the Surprise Billing Protection Act, "health benefits plan" does not include any of the following:

(1) an accident-only policy;

(2) a credit-only policy;

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

(4) a specified disease policy;

(5) a medicare supplement policy;

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

(7) a fixed indemnity policy;

(8) a dental-only policy;

(9) a vision-only policy;

(10) a workers' compensation policy;

(11) an automobile medical payment policy; and

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

Q. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by this or another state to provide health care services in the regular course of business;

R. "health care service" means any service,

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supplies or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease and includes, to the extent offered by a health benefits plan, physical, behavioral and mental health services, including community-based mental health services and services for developmental disability or developmental delay;

S. "health carrier" means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, including a health insurance company, fraternal benefit society, vision plan or pre-paid dental plan, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan, a third-party, 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 health benefit plans and managed health care plans in this state;

T. "health information" means any information or data, except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider, health care insurer or the consumer that relates to:

(1) the past, present or future physical, mental or behavioral health or condition of an individual;

(2) the provision of health care to an

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individual; or

(3) payment for the provision of health care to an individual;

U. "hospital" means a facility offering inpatient services, nursing and overnight care on a twenty-four-hour basis for diagnosing, treating and providing medical, psychological or surgical care for three or more separate individuals who have a physical or mental illness, disease, injury or a rehabilitative condition or are pregnant;

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

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

X. "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 or under contract with or employed by the health carrier;

Y. "nonparticipating provider" means a provider who is not a participating provider; provided that as it relates to covered emergency services, a facility is a nonparticipating provider if the facility has not contracted with a health carrier to provide emergency services at a specified rate;

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Z. "nonpublic personal health information" means:

(1) health information that identifies the individual who is the subject of the information; or

(2) health information about which there is a reasonable basis to believe could be used to identify an individual;

AA. "participating provider" means a provider or facility who, under express contract with a health carrier or with its 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 carrier, subject to copayments, coinsurance, deductibles or other cost-sharing provisions. The contract between the participating provider and the health carrier prohibits the participating provider from balance billing to covered persons;

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

CC. "provider" means a licensed health care professional, hospital or other facility authorized to furnish health care services in this state;

DD. "provider group" means two or more providers legally organized in a partnership, professional corporation or

limited liability company formed to render health care services; a medical foundation; a not-for-profit corporation; a faculty practice plan; or other similar entity that satisfies one of the following criteria; provided that an entity that otherwise meets the definition of "provider group" pursuant to this subsection shall be considered a provider group although its shareholder, partners or owners of the provider group include single-provider professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual providers:

(1) each provider that is a member of the group provides substantially the full range of services that any provider in the group routinely provides, including medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel;

(2) substantially all of the services of the providers who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; and

(3) the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group;

EE. "rebate" means a return of part of a payment service as a discount or reduction;

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FF. "record custodian" means the superintendent, a resolution organization assigned pursuant to Section 10 of the Surprise Billing Protection Act, or any other person who possesses or controls a confidential record;

GG. "resolution organization" means a qualified independent third-party claim dispute resolution;

HH. "stabilize" means to provide medical or mental health treatment of a condition 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 individual from a facility or, with respect to an emergency medical condition, to deliver, including the delivery of a placenta;

II. "superintendent" means the superintendent of insurance or the office of superintendent of insurance; and

JJ. "trade secret" means information that is protected by the Uniform Trade Secrets Act or as otherwise provided by state and federal law."

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

"[NEW MATERIAL] SURPRISE BILL--DEFINED.--

A. A surprise bill for health care services is a bill for:

(1) an emergency medical, mental or behavioral health service or ambulance service provided to a covered

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person by a nonparticipating provider;

(2) services rendered by a nonparticipating provider at a participating facility, where a participating provider is unavailable or a nonparticipating provider renders unforeseen services, or unforeseen medical, mental or behavioral health services that arose at the time the health care services are rendered; or

(3) services rendered by a nonparticipating provider when the covered person was referred by a participating provider to a nonparticipating provider without the covered person's written acknowledgement that the participating provider is referring the covered person to a nonparticipating provider and that the referral may result in costs not covered by the health benefits plan.

B. "Surprise bill" does not mean a bill received for health care services when a participating provider is available and the covered person has elected to obtain services from a nonparticipating provider.

C. Nothing in this section shall be construed to prohibit a health carrier from appropriately utilizing reasonable medical management techniques."

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

"[NEW MATERIAL] EMERGENCY SERVICES--COVERAGE.--

A. A health carrier shall:

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(1) cover those services necessary to screen and stabilize a covered person in a situation where a prudent layperson acting reasonably would believe that an emergency medical condition exists;

(2) cover emergency services necessary to screen and stabilize a covered person at a participating or nonparticipating hospital emergency department if a prudent layperson would reasonably believe that use of a participating hospital emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider or facility; and

(3) provide coverage for emergency services regardless of whether the services are furnished by a participating provider or nonparticipating provider.

B. A health carrier shall not require that prior authorization for emergency services be obtained by or on behalf of a covered person prior to the point of stabilization of that covered person if a prudent layperson acting reasonably would believe that an emergency medical condition or behavioral health condition exists.

C. A health carrier is solely liable for payment of fees to a nonparticipating provider of covered emergency services provided to a covered person as otherwise provided by law.

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D. A health carrier may impose a coinsurance, copayment or limitation of benefits requirement for a nonparticipating provider only to the same extent that the coinsurance, copayment or limitation of benefits requirement applies to a participating provider."

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

"[NEW MATERIAL] NON-EMERGENCY SERVICES COVERAGE.--

A. A health carrier is solely liable for payment of fees to a nonparticipating provider of covered non-emergency services provided to a covered person in accordance with the coverage terms of a health benefits plan, and a covered person shall not be liable for payment of fees to a nonparticipating provider, other than applicable copayments, coinsurance and deductibles, for covered non-emergency services that are provided:

(1) in a facility that has a contract for the non-emergency services with the health carrier that the facility would be otherwise obligated to provide under contract with the health carrier;

(2) when the covered person does not have the ability or opportunity to choose a participating provider who is available to treat the covered person; or

(3) when medically necessary care is unavailable within a health benefits plan's network; provided

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that medical necessity shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan.

B. Nothing in this subsection shall preclude a health carrier's use of reasonable medical management in providing benefits to a covered person."

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

"[NEW MATERIAL] HOLD HARMLESS--COLLECTIONS REFERRALS--ASSIGNMENT OF BENEFITS--CREDIT AGAINST MAXIMUM OUT-OF-POCKET COST-SHARING AMOUNT.--

A. If a covered person receives a health care service from a nonparticipating provider, the nonparticipating provider shall not knowingly submit a surprise bill to the covered person for any amount in excess of the cost-sharing amounts that would have been imposed if the health care service had been rendered by a participating provider. The covered person's health carrier shall submit to the nonparticipating provider upon request a statement of the applicable in-network cost-sharing amounts owed by the covered person to the nonparticipating provider. The covered person shall be responsible for no more than the cost-sharing amounts that would have been due if the health care service had been rendered by a participating provider.

B. A nonparticipating provider shall not refer to

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collections a surprise bill.

C. A health benefits plan shall allow for assignment of benefits as outlined below:

(1) a nonparticipating provider of a health care service that does not knowingly submit a surprise bill to a covered person is deemed to have received an assignment of benefits from the covered person, and any reimbursement paid to the nonparticipating provider by the covered person's health benefits plan shall be paid directly to the nonparticipating provider. This provision waives any requirements for consent to assign benefits as otherwise provided pursuant to state law; and

(2) if a covered person receives a surprise bill, the covered person may submit a surprise bill complaint form to the covered person's health carrier in accordance with the provisions of Section 8 of the Surprise Billing Protection Act. Submission of the surprise bill complaint form to the health carrier shall effect an assignment of the covered person's benefits to the nonparticipating provider. Except in the case of insurance fraud, a health carrier shall hold harmless a covered person who submits a surprise bill complaint form to the covered person's health carrier against all but the in-network cost-sharing amount that would otherwise have been due.

D. A health carrier shall count toward a covered

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person's in-network deductible and maximum out-of-pocket cost-sharing amount each payment that a covered person makes to satisfy a surprise bill in accordance with the provisions of the Surprise Billing Protection Act."

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

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

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

"[NEW MATERIAL] SURPRISE BILL COMPLAINT FORM--COMMUNICATION BY HOSPITALS--ADVANCE NOTIFICATION OF CHARGES FOR HEALTH CARE SERVICES.--

A. A surprise bill complaint form shall permit a covered person to declare the bill to be a surprise bill and to assign the covered person's benefits to the nonparticipating provider in accordance with the provisions of Subsection C of Section 6 of the Surprise Billing Protection Act.

B. When a covered person receives a health care

service that may be subject to a surprise bill, each provider, facility and health carrier in any way associated with the service shall make a good-faith effort to apprise the covered person of the protections afforded pursuant to the Surprise Billing Protection Act and provide to the covered person a surprise bill complaint form and instructions for submitting it to the covered person's health carrier. In addition to providing information in the evidences of coverage, the health carrier shall explain the availability of the form on any explanation of benefits provided to the covered person.

C. By December 31, 2017:

(1) the superintendent shall adopt and promulgate rules to specify the content and format of a surprise bill complaint form that accords with the provisions of the Surprise Billing Protection Act. The superintendent shall make the complaint form available in a publicly accessible manner on the superintendent's website and in paper format upon request;

(2) a health carrier shall post on its website in a publicly accessible manner and in paper format upon request:

(a) the surprise bill complaint form established pursuant to the superintendent's rules; and

(b) language notifying covered persons of their rights pursuant to the Surprise Billing Protection Act

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with an explanation of benefits; and

(3) each hospital shall post in a publicly accessible manner on its website:

(a) the names and hyperlinks for direct access to the websites of all health benefits plans for which the hospital contracts as a network provider or participating provider;

(b) a statement that: 1) services may be provided in the hospital by participating providers as well as other providers who may separately bill the patient; 2) providers that provide health care services in the hospital may or may not participate with the same health benefits plans as the hospital; and 3) prospective patients should contact the provider that will provide services in that hospital to determine in which health benefits plan networks the provider participates as a network provider or preferred provider;

(c) the rights of covered persons under the Surprise Billing Protection Act; and

(d) information for the superintendent.

D. Any communication, including a bill, detailing the cost of a health care service covered by the Surprise Billing Protection Act shall clearly state that the covered person will only be responsible for payment of the applicable cost-sharing amounts under the covered person's health benefits plan.

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E. Prior to an admission, procedure or health care service and upon request by a covered person, a health carrier shall within five working days disclose either of the following:

(1) the allowed amount of the admission, procedure or health care service, including any facility fees required, if the provider is in the covered person's health benefits plan network; or

(2) amount that will be charged for the admission, procedure or service, including any facility fees required if the provider is outside of the covered person's health benefits policy network.

F. If a health carrier is unable to quote a specific amount as required in Subsection E of this section in advance due to the provider's inability to predict the specific treatment or diagnostic code, the health carrier shall do all of the following:

(1) disclose the incomplete nature of the estimate;

(2) inform the covered person of the provider's ability to obtain an updated estimate once additional information is obtained; and

(3) disclose what is known concerning:

(a) the estimated allowed amount for a proposed admission, procedure or health care service, including

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any facility fees required, if the provider is in the covered person's network; or

(b) the estimated amount that will be charged for a proposed admission, procedure or health care service, including any facility fees required, if the provider is outside of the covered person's network.

G. A health carrier may disclose information comparing the price for the required health care service at the selected hospital with other hospitals within the health carrier's health benefits plan network.

H. The requirements of this section do not apply to unscheduled health care services or health care services scheduled fewer than five days prior to the provision of the health care service."

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

"[NEW MATERIAL] OVERPAYMENT.--

A. If a covered person pays a nonparticipating provider more than the in-network cost-sharing amount, the nonparticipating provider shall refund to the covered person within one hundred business days of receipt any amount paid in excess of the in-network cost-sharing amount.

B. If a nonparticipating provider has not made a full refund of any amount paid in excess of the in-network cost-sharing amount to the covered person within thirty

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business days of receipt of the overpayment, interest shall accrue at the rate of ten percent per year beginning with the first calendar day after the thirty-business-day period.

C. The superintendent shall adopt and promulgate rules pursuant to this section."

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

"[NEW MATERIAL] DIRECT DISPUTE RESOLUTION--PAYMENT FOR HEALTH CARE SERVICES.--

A. Nothing in the Surprise Billing Protection Act shall prevent a health carrier and a nonparticipating provider from mutually agreeing to a payment amount for a health care service outside of the mechanism set forth in this section, nor shall any provision of the Surprise Billing Protection Act be construed to prevent a health carrier from addressing the availability and use of participating providers in its contracts with in-network facilities and participating providers who make referrals to other providers.

B. If a health carrier receives a surprise bill complaint form and a bill from a covered person, or if a nonparticipating provider submits a bill for a health care service:

(1) the health carrier and nonparticipating provider may reach an agreement as to an amount to be paid for the nonparticipating provider's services, payment of which, in

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1 addition to the applicable in-network cost-sharing amount owed
2 by the covered person, shall constitute payment in full to the
3 nonparticipating provider for the health care service rendered;
4 and
5 (2) the health carrier shall pay in accordance
6 with the prompt pay requirements under state and federal law.
7 C. If a nonparticipating provider and a health
8 carrier do not reach agreement on a payment amount through the
9 negotiation process outlined in this section within forty-five
10 calendar days after the health carrier received the bill for
11 the health care service, either party may submit a formal
12 dispute resolution request to the superintendent to include all
13 claims pertaining to a covered person from a single episode of
14 illness.
15 D. Calculation of the date of health carrier
16 receipt of the bill shall align with prompt pay requirements
17 under applicable state and federal law.
18 E. A health carrier's failure to respond within
19 forty-five days to a nonparticipating provider's request for
20 payment via a surprise bill complaint form shall constitute
21 acceptance of the nonparticipating provider's charges. Payment
22 of accepted charges shall align with prompt pay requirements
23 pursuant to Section 59A-16-21.1 NMSA 1978."
24 **SECTION 11.** A new section of the New Mexico Insurance
25 Code is enacted to read:

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"[NEW MATERIAL] INDEPENDENT DISPUTE RESOLUTION--COSTS.--

A. A health carrier or nonparticipating provider may initiate binding arbitration to determine reimbursement for health care services provided by a nonparticipating provider. Failure to respond within fifteen days to a nonparticipating provider's request for arbitration on a disputed payment shall constitute acceptance of the nonparticipating provider's charges. Payment of accepted charges shall align with prompt pay requirements pursuant to Section 59A-16-21.1 NMSA 1978.

B. Arbitration shall be initiated by filing a request with the superintendent. The parties may agree to resolve disputes over additional reimbursement for services for multiple covered lives or enrollees.

C. The superintendent shall publish a list of resolution organizations or arbitrators that provide binding arbitration.

D. Both parties must agree on an arbitrator from the list within five business days of submission of a request for arbitration.

E. If no agreement can be reached, a list of five arbitrators will be provided. From the list of five arbitrators, the party initiating arbitration shall first veto two arbitrators and then the other party shall veto two arbitrators from the remaining list. The remaining arbitrator shall be the chosen arbitrator.

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F. The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer to resolve the dispute over reimbursement for services provided before arbitration occurs. In response to this notice, the non-requesting party shall inform the requesting party of its final offer before arbitration occurs.

G. The arbitrator's review shall consist of a review of both parties' final offers submitted to resolve the dispute over reimbursement for services. The arbitrator's decision may be one of the two amounts submitted by the parties as their final offers or another amount determined to be reasonable by the arbitrator. If the arbitrator finds that, given the final offers, a settlement between the health carrier and the nonparticipating provider is reasonably likely or that the final offers represent unreasonable extremes, the arbitrator may direct both parties to attempt a good-faith negotiation for settlement. The health carrier and nonparticipating provider may be granted up to ten days for this negotiation, which shall run concurrently with the thirty-day period for dispute resolution.

H. In making a determination pursuant to this section, the arbitrator may consider, and the parties shall provide at the resolution organization's request, documentation of the following:

(1) the individual covered person's

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characteristics;

(2) the level of training, education and experience of the nonparticipating provider;

(3) the nonparticipating provider's usual charge for comparable services provided out-of-network with respect to any health benefits plans;

(4) the participating provider contracted rate of payment for comparable services;

(5) the usual and customary provider charges, as defined by a public independent database of charges, for the same or similar services in the same geographic area;

(6) the amount that would be paid under health coverage pursuant to health coverage under Part A or Part B of Title 18 of the federal Social Security Act, as amended, or federal-state medical assistance provided pursuant to Title 19 or 21 of the federal Social Security Act for the service;

(7) the circumstances and complexity of the particular case, including the time and place of the service;

(8) the availability of the health care service for the covered person from participating providers;

(9) any payments made in prior surprise bill disputes between the provider and the health carrier; and

(10) the propensity of the provider to be included in health carrier networks.

I. The arbitrator shall issue a written decision

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within thirty days after assignment of the dispute for resolution. Copies of any written findings of fact shall be provided to both parties and the superintendent by the same means, whether electronic or hard copy.

J. The determination obtained through the resolution process pursuant to this section shall be binding on both parties and not appealable.

K. A final determination as to a claim code of a service shall be binding on the health carrier and the provider for any disputes between them involving the same claim code for a period of one year from the date of the determination.

L. The arbitrator's expenses and fees, together with other expenses, excluding attorney fees, incurred in the conduct of the arbitration shall be shared by the parties to the arbitration.

M. A party that fails to pay all amounts due to the other party and to the resolution organization within thirty days of receiving the final determination shall:

(1) pay interest to the resolution organization and to the prevailing party at one and one-half percent per month; and

(2) be subject to a penalty of one hundred dollars ($100) per day, payable to the current school fund, until all payments are made in full.

N. Nothing in this section shall preclude the

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parties from reaching a resolution of their dispute before the arbitrator issues its decision.

O. A resolution organization shall:

(1) protect from disclosure, including in the information provided to the superintendent, any information specifically identifying the covered person who received the health care services that were the subject of an arbitration decision. The information shall be protected and remain confidential in compliance with all applicable federal and state laws and shall be confidential as a record pursuant to applicable state and federal law; and

(2) report to the superintendent any change in its status that would cause it to cease performing or being qualified to perform arbitrations pursuant to the Surprise Billing Protection Act."

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

"[NEW MATERIAL] RECORDS--CONFIDENTIALITY--EXCEPTIONS--SUPERINTENDENT ANALYSIS--DISCLOSURE.--

A. A record custodian shall not disclose confidential information disclosed pursuant to the dispute resolution process established pursuant to the Surprise Billing Protection Act. A record containing confidential information is:

(1) confidential and privileged;

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(2) not subject to the Inspection of Public Records Act;

(3) not subject to subpoena; and

(4) not subject to discovery or admissible as evidence in any private civil action.

B. A record custodian may disclose confidential information to the superintendent or resolution organization to facilitate the fulfillment of a duty or obligation under the Surprise Billing Protection Act. Any duty or obligation that requires the use of confidential information includes:

(1) arbitration of a disputed claim;

(2) resolution of a consumer complaint; and

(3) investigation of an alleged violation of the Surprise Billing Protection Act.

C. The provisions of this section do not prevent the superintendent from using confidential information for internal analysis or from disclosing aggregated confidential information in a way that the identity of the subject of the information cannot be ascertained.

D. The sharing of a record with, to or by the superintendent or resolution organization as authorized by the Surprise Billing Protection Act does not constitute a waiver of any applicable privilege or claim of confidentiality.

E. The rights to confidentiality conferred under this section do not create a private right of action."

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

"[NEW MATERIAL] ENFORCEMENT.--

A. The superintendent shall ensure compliance with the Surprise Billing Protection Act. The superintendent may investigate potential violations of that act based upon information received from covered persons, health carriers, providers and other sources in order to ensure compliance with the provisions of that act.

B. Upon satisfactory evidence of a violation of the Surprise Billing Protection Act by a health carrier, the superintendent may, at the superintendent's discretion, pursue any one of the following courses of action:

(1) enter a cease and desist order;

(2) impose a civil penalty of not more than five thousand dollars ($5,000) for each action in violation of a provision of the Surprise Billing Protection Act. Any action taken to impose a civil penalty shall comply with applicable state and federal law;

(3) impose a civil penalty of not more than ten thousand dollars ($10,000) for each action in willful violation of a provision of the Surprise Billing Protection Act; or

(4) impose any other penalty or remedy deemed appropriate by the superintendent, including restitution.

C. Fines imposed against an individual health carrier under this section may not exceed three hundred thousand dollars ($300,000) in the aggregate during a single calendar year.

D. The enforcement remedies under this section are in addition to any other remedies or penalties that may be imposed under any other applicable law."

SECTION 14. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PRIVATE CAUSE OF ACTION.--Nothing in the Surprise Billing Protection Act shall be construed to create or imply a private cause of action for a violation of that act."

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

"[NEW MATERIAL] RULEMAKING.--The superintendent shall promulgate rules as may be necessary to appropriate or implement the provisions of the Surprise Billing Protection Act."

SECTION 16. [NEW MATERIAL] SEVERABILITY.--If any part or application of the Surprise Billing Protection Act is held invalid, the remainder or its application to other situations or persons shall not be affected."

SECTION 17. APPLICABILITY.--The provisions of the Surprise Billing Protection Act apply to the following health coverage delivered or issued for delivery in this state:

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

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

C. group and blanket health insurance policies, health care plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

D. individual and group health maintenance organization plan contracts governed by the provisions of the Health Maintenance Organization Law; and

E. individual and group nonprofit health care plan contracts governed by the provisions of the Nonprofit Health Care Plan Law.

SECTION 18. EFFECTIVE DATE.--The effective date of the provisions of this act is October 1, 2017.

underscored material = new
[~~bracketed material~~] = delete