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, ACCEPTABLE METHODS OF PAYMENT AND NETWORK LEASING.

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:

"DENTAL COVERAGE--PRIOR AUTHORIZATION.--

A. For purposes of this section, "prior authorization" means a written communication indicating whether a specific service is covered or multiple services are 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 prescribed 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 insured's condition occurs that would cause prior-authorized services to no longer be medically necessary, based on prevailing standards of care;

(4) subsequent to the issuance of a prior authorization, new services are provided to the insured or a change in the insured's condition occurs such that the prior-authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the insured's plan in effect at the time the request for prior authorizations was made; or

(5) 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:

"DENTAL COVERAGE--DESIGNATION OF PAYMENT.--

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

(1) option for the designation of payment 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:

"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 appeal the recovery being sought as set forth in Subsection C of this section.

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 the original payment for a claim was made unless

the claim was fraudulent or intentionally misrepresented.

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 unless the plan:

(1) notifies the provider, in writing, within twelve months of the erroneously paid claim; and

(2) advises the provider that an automatic deduction shall occur within forty-five days of receiving notification unless the provider submits a written appeal to the plan pursuant to the grievance rules prescribed by the superintendent of insurance.

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:

"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 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:

"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 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. At a time when a contract relevant to granting access to a provider network to a third party is entered into or renewed, or when there are material modifications made, a contracting entity shall not require a provider to participate in third-party access to the provider network contract or contract directly with a third party that acquired the provider network. If a provider opts out, the contracting entity shall not cancel or otherwise end a contractual relationship with the provider. When initially contracting with a provider, a contracting entity must accept a qualified provider even if the provider rejects a network lease provision.

C. 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 the 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) 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

(d) 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.

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

E. The provisions of this section shall not apply if access to a provider network contract is granted to a dental carrier of an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website."

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

"59A-23G-1. SHORT TITLE.--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:

"DENTAL PLAN--PRIOR AUTHORIZATION.--

A. For purposes of this section, "prior authorization" means a written communication indicating whether a specific service is covered or multiple services are 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

prescribed 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;

(4) 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 such that the prior-authorized procedure would at that time

require disapproval pursuant to the terms and conditions for coverage under the covered person's plan in effect at the time the request for prior authorization was made; or

(5) 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 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:

"DENTAL PLAN--DESIGNATION OF PAYMENT.--

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 designation of payment 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:

"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 appeal the recovery being sought as set forth in Subsection C of this section.

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

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

a different claim unless the plan:

(1) notifies the provider, in writing, within twelve months of the erroneously paid claim; and

(2) advises the provider that an automatic deduction shall occur within forty-five days of receiving notification unless the provider submits a written appeal to the plan pursuant to the grievance rules prescribed by the superintendent of insurance.

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:

"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 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:

"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;

(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. At a time when a contract relevant to granting access to a provider network to a third party is entered into or renewed, or when there are material modifications made, a contracting entity shall not require a provider to participate in third-party access to the provider network contract or contract directly with a third party that acquired the provider network. If a provider opts out, the contracting entity shall not cancel or otherwise end a contractual relationship with the provider. When initially contracting with a provider, a contracting entity must accept a qualified provider even if the provider rejects a network lease provision.

C. 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 the 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 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) 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

(d) 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.

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

E. The provisions of this section shall not apply if access to a provider network contract is granted to a

dental carrier of an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website."

SECTION 12. APPLICABILITY.--The provisions of this act apply to dental plans issued for delivery or renewed in this state on or after January 1, 2024.