

NEW MEXICO

According to the New Mexico Patient Protection Act (Chapter 59A, Article 57), reasonable access must be provided to out-of-network health care if necessary to provide continuity of care during brief transition periods. This could be construed to mean that patients who receive care at an in-network facility by an out-of-network provider will be covered by their insurer, as this ensures continuity of care.

Additionally, Health Benefit Plans (Chapter 59A, Article 22A-5) specifies that that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider that care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider. It also states that if a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider. This section tends to imply an insurer must pay an out-of-network provider providing covered services at an in-network facility a fee similar to that of an in-network provider.

The relevant articles and sections of these chapters are attached and include: Patient Protection and Health Benefits Plans and Penalty.

There is nothing in the New Mexico statutes that expressly prohibits balance billing. However, verbiage within the chapters suggests that insurers can be held accountable for covered services provided at in-network facilities.

59 A-57-4. Patient rights; disclosures; rights to basic and comprehensive health care services; grievance procedure; utilization review program; continuous quality program

(A. Each covered person enrolled in a managed health care plan has the right to be treated fairly. A managed health care plan shall arrange for the delivery of good quality and appropriate health care services to enrollees as defined in the particular subscriber agreement. The department shall adopt regulations to implement the provisions of the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978] and shall monitor and oversee a managed health care plan to ensure that each covered person enrolled in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting regulations to implement the provisions of Subparagraphs (a) and (b) of Paragraph (3) and Paragraphs (5) and (6) of Subsection B of this section regarding health care standards and specialists, utilization review programs and continuous quality improvement programs, the department shall cooperate with and seek advice from the department of health.

B. The regulations adopted by the department to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment, a managed health care plan shall provide a summary of benefits and exclusions, premium information and a provider listing; within a reasonable time after enrollment and at subsequent periodic times as appropriate, a managed health care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons;

(2) a managed health care plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

(3) in providing reasonably accessible health care services that are available in a timely manner, a managed health care plan shall ensure that:

(a) the plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the plan's enrollees;

(b) health care providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all basic health care services that are required of them by a managed health care plan;

(c) reasonable access is provided to out-of-network health care providers if medically necessary covered services are not reasonably available through participating health care providers or if necessary to provide continuity of care during brief transition periods;

(d) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; and

(e) the plan, through provider selection, provider education, the provision of additional resources or other means, reasonably addresses the cultural and linguistic diversity of its enrollee population;

(4) a managed health care plan shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network. The grievance procedure shall notify patients of their right to obtain review by the plan, their right to obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Patient Protection Act [Chapter 59A, Article 57 NMSa 1978];

(5) a managed health care plan shall adopt and implement a comprehensive utilization review program. The basis of a decision to deny care shall be disclosed to an affected enrollee. The decision to approve or deny care to an enrollee shall be made in a timely manner, and the final decision shall be made by a qualified health care professional. A plan's utilization review program shall ensure that enrollees have proper access to health care services, including referrals to necessary specialists. A decision

made in a plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the superintendent; and

(6) a managed health care plan shall adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the plan.

59A-22A-5. Health benefit plans

A. Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber agreement shall contain at least the following provisions:

(1) a provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider that emergency care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(2) a provision which clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of non-preferred providers.

B. If a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

59A-57-11. Penalty

In addition to any other penalties provided by law, a civil administrative penalty of up to ten thousand dollars (\$10,000) may be imposed for each violation of the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978]. An administrative penalty shall be imposed by written order of the superintendent made after holding a hearing as provided for in Chapter 59A, Article 4 NMSA 1978.