FISCAL IMPACT REPORT

SPONSOR Gallegos/Dixon/Serrato **LAST UPDATED** **ORIGINAL DATE** 02/26/2025

SHORT TITLE Prior Authorization Process Exemptions **BILL NUMBER** House Bill 461

ANALYST Rommel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
OSI	$0	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Recurring	Other state funds
HCA	$0.0	$39.5	$39.5	$79.0	Recurring	General Fund
HCA	$0.0	$39.5	$39.5	$79.0	Recurring	Federal Funds
Independent Review Organization	$0.0	$218.0	$218.0	$436.0	Recurring	General Fund
HCA	$0.0	$60.0	$0.0	$0.0	Nonrecurring	General Fund
HCA	$0.0	$540.0	$0.0	$0.0	Nonrecurring	Federal Funds
Total	$0.0	$897.0	$297.0	$1194.0		

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Relates to Senate Bills 39, 207, 263 and House Bill 570

Sources of Information

LFC Files

Agency Analysis Received From
New Mexico Public School Insurance Authority (NMPSIA)
Retiree Health Care Authority (RHCA)
Office of the Superintendent of Insurance (OSI)
Health Care Authority (HCA)
UNM Health Sciences Center (UNM-HSC)

SUMMARY

Synopsis of House Bill 461

House Bill 461 (HB461) adds a new section to Chapter 59A, Article 22B NMSA 1978, the Prior Authorization Act. The bill establishes a process for granting exemptions from the prior authorization process for a healthcare service.

HB461 creates evaluation periods beginning January and June (see Technical Issues). If a healthcare provider, in the past six month evaluation period, has had ninety percent of prior

authorizations approved for a service, the provider may request an exemption from prior authorization. A health insurer may determine whether to continue or rescind an exemption once per evaluation period. If an insurer rescinds a prior authorization exemption, the provider has the right to request an independent review of the determination. The insurer may not require a provider to engage in an internal appeal process before requesting an independent review. The independent review, if requested by the provider, will be conducted by the following process:

(1) The independent review organization shall complete a review of an adverse decision within thirty days after a request is filed;
(2) A provider may request that the independent reviewer review another sample of claims than those reviewed by the insurer;
(3) The review shall be conducted by a person licensed to practice medicine in New Mexico, and, if the provider is a physician, the review shall be made by a person licensed to practice in the same or similar specialty;
(4) The insurer shall pay for an independent review of a decision to rescind as well as for any copies of records necessary to conduct the review;
(5) Both parties are bound by the independent review organization's decisions; and
(6) If the review overturns the insurer's determination to rescind a prior authorization exemption, the insurer shall not attempt to rescind that exemption again until the beginning of the next evaluation period.

If the independent reviewer affirms the insurer's determination to rescind, the insurer shall not retroactively deny any prior authorizations granted on the basis of a rescission of an exemption, and the provider is eligible to apply for a new exemption during the following evaluation period.

The effective date of this bill is January 1, 2026.

FISCAL IMPLICATIONS

HB461 contains no appropriation.

The Office of the Superintendent of Insurance (OSI) does not anticipate any significant fiscal impact from the enactment of SB263.

The Health Care Authority (HCA) comments on the fiscal impact:

> This bill only edits the insurance code (Chapter 59) so it is not clear that it applies to Medicaid. If it does apply to Medicaid, HCA would need a full-time Pharmacy Technician III to implement this program for Fee-for-Service Medicaid and for oversight of the Managed Care Organization (MCO) prior authorization exemption program. The cost of a Pharmacy Technician III annually is $78.9 thousand which is split $39.5 thousand from the general fund and $39.5 thousand from federal funds.
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> Contracting with an independent review organization and accessing medical records will increase operating costs for the Medical Assistance Division. In another state the cost for each prior authorization exemption request was $460. Based on the "New Mexico Health Care Workforce Committee 2024 Annual Report" there are 5,270 Primary Care Physicians, OB-GYN Physicians, Psychiatrists, Physician Assistants, Nurse Practitioner and Nurse Midwives. Assuming 90% are registered with Medicaid and only 10% of those 4,743 providers request exemption per year there would be an additional cost of $218

thousand per year.

This bill will likely impact State Health Benefits (SHB), but the cost to the plan is indeterminable. SHB has requested an administrative and fiscal impact from its administrative services organizations and will update its analysis if there are any major issues identified. The administrative burden on SHB could increase due to additional system tracking, monitoring of provider exemption lists, and oversight responsibilities to ensure compliance with fraud, waste, and abuse prevention measures. If implementation of prior authorization exemptions leads to increased utilization of certain services or medications, it could affect overall plan costs. Increased utilization without prior authorization oversight may also impact the SHB's ability to negotiate provider rates or identify cost-saving opportunities through utilization management strategies.

The Financial Services (FS) Module of the Medicaid Management Information System Replacement (MMISR) will require a system change to implement this bill. The change is expected to occur in state fiscal year 2026 and would cost approximately $600 thousand to complete. This is anticipated to be with 90 percent federal funds and 10 percent state funds, or $540 thousand federal funds and $60 thousand state funds

SIGNIFICANT ISSUES

A 2023 U.S. Health and Human Services Office of the Inspector General report expressed concern that some people enrolled in Medicaid managed care may not be receiving all medically necessary health care services intended to be covered based upon: (1) the high number and rates of denied prior authorization requests by some managed care organizations (MCOs), (2) the limited oversight of prior authorization denials in most states, and (3) the limited access to external medical reviews.[1]

Four states (AR, TX, VT and WV) have enacted comprehensive prior exemption laws similar to SB263 while several other states have at least some requirements waiving prior authorizations for certain services (e.g., for certain prescription drugs).[2] Specifics vary from state to state, but in general they aim to reduce volume of prior authorization requirements, reduce patient care delays, increase public access to data, and improve transparency about which medications and procedures require prior authorization.

Currently, as outlined in New Mexico Administrative Code 13.10.31.12, insurers are required to review prior authorization requirements annually, which includes the approval rate for each covered benefit and selection of practitioners exempt from prior authorization requirements.

ADMINISTRATIVE IMPLICATIONS

HCA notes:

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[1] High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care https://oig.hhs.gov/documents/evaluation/3157/OEI-09-19-00350-Complete%20Report.pdf

[2] 2024 Prior Authorization State Law Chart | AMA https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf

> This bill limits the exemptions by insurance type. If a provider maintains a high rate of approval, they would be required to go through this process with each insurance company separately. In Medicaid this would apply to five plans: four managed care plans and one Fee-for-Service plan. Exempting from all applicable plans could be laborious on providers. Oversight post prior authorization exemption could limit the MCO and HCA's ability to evaluate for high utilization of inappropriate medication prescribing if a clinician's prescribing practice changed.

OSI may need to promulgate rules articulating the structure and duties of independent review organizations and its reviewers.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

This bill relates to Senate Bill 39 would amend the Prior Authorization Act to prohibit prior authorization and step therapy—the insurance plan practice of requiring patients to try less expensive medication first—for medications that are prescribed for on-label or off-label use for the treatment of rare disease or medical condition that affects fewer than 200 thousand people in the United States.

This bill relates to Senate Bill 207 would modify the Prior Authorization Act to mandate coverage for medications prescribed for both on-label and off-label use. It also adds the treatment of rare diseases to the list of exceptions that do not require prior authorization, alongside autoimmune disorders, cancer, and substance use disorders.

This bill relates to House Bill 570 adds a new section to the Prior Authorization Act of the Insurance Code to eliminate prior authorization requirements for chemotherapy, dialysis, elder care, and home health care services.

Senate Bill 263 is a near duplicate of HB461, with identical language regarding the independent review process. HB461 adds specific definitions for "abuse", "evaluation period" and "fraud" not included in Senate Bill 263.

TECHNICAL ISSUES

HB461 defines evaluation period as "a six-month period beginning each January and each June" (page 2, line 10). Assuming the first period begins January 1, the second period would need to begin July 1.

OSI suggests a "random sample" of claims (page 4, line 3) may not be an accurate representation. Use of generally accepted auditing principles and practices as they apply to medical claims audit would be more appropriate.

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