LFC Requester:	Harry Rommel

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
AgencyAnalysis.nmlegis.gov and email to **billanalysis@dfa.nm.gov**
(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared *2-04-2026*
Bill Number: *HB302*

Check all that apply:
Original *X* Correction __
Amendment __ Substitute __

Sponsor: Representative Doreen Y. Gallegos

Agency Name and Code Number: Office of Superintendent of Insurance -440

Person Writing Viara Ianakieva

Short Title: PRIOR AUTHORIZATION EXEMPTIONS

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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	**FY27**		
N/A	N/A	N/A	N/A

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	**FY27**	**FY28**		
N/A	N/A	N/A	N/A	N/A

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total						

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: HB451 (2025) and SB263 (2025)
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

House Bill 302 (HB302) amends the Prior Authorization Act in the Insurance Code (Chapter 59A, Article 22B) to add a new section that requires health insurers to establish procedures to grant exemption to certain health care professionals from the health insurer's prior authorization process.

HB302 requires that no sooner than thirty days after the end of an evaluation period, a participating health care professional may apply for an exemption from its prior authorization process, including recommended clinical review, for outpatient health care services. A health insurer is required to grant the exemption request in writing, if: (1) during the evaluation period prior to the exemption request, no less than ninety percent of the health care professional's ten or more prior authorization requests for outpatient health care services have been approved by the health insurer upon initial submission; or (2) after successful appeal. A health insurer is also required to provide a written explanation including data, for any denial of a request for an exemption, sufficiently demonstrating how the request failed to meet the criteria established.

When a request for exemption is approved, the health insurer must provide the health care professional with information regarding the effective date of the exemption and must also determine whether to continue or rescind a health care professional's exemption during each evaluation period.

Exemptions may only be rescinded by a health insurer if: (1) the health insurer determines that less than ninety percent of the claims submitted by the health care professional during the previous evaluation period would have met the applicable medical necessity criteria; and (2) upon provision of written notice within twenty-five days before the rescission takes effect.

If a health insurer finds a health care professional has committed fraud or abuse in their exemption request, the health insurer may immediately or retroactively rescind all exemptions upon written notice with explanations and sample information used to make the determination, to the health care professional. Health care professionals have a right to request an independent review of the determination to rescind an exemption. A health insurer cannot require an internal appeal before any request for independent review of a decision to rescind an exemption.

Health insurers are required to pay for the independent review and decisions upon independent review of a physician, shall be made by a person licensed to practice medicine in the state who practices in the same or similar specialty as the physician requesting the review. The Medical Board is allowed to request a reasonable fee for copies of medical records, or other documents necessary for the independent review, that are requested from the health care professional.

Subsection B of Section 1 establishes the following definitions: (1) "abuse" means health care professional practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the health insurer or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; (2) "evaluation period" means a six-month period beginning each January and each June; (3) "fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the

deception could result in some unauthorized benefit to the person or another person and includes any act that constitutes fraud under applicable federal or state law; and (4) "outpatient health care services" does not include pharmaceutical services or the provision of prescription drug products or supplies.

The Superintendent of Insurance is required to conduct a rulemaking in accordance with this new section no later than December 31, 2026.

The effective date of this bill is May 20, 2026.

FISCAL IMPLICATIONS
None.

SIGNIFICANT ISSUES
None.

PERFORMANCE IMPLICATIONS
Specialists who perform the same type of treatment or procedure repeatedly, and whose services consistently require prior authorization, can more easily achieve the 90% threshold. In contrast, general practitioners with a more varied practice, or those with fewer instances of identical prior authorization requests, face greater challenges in meeting this benchmark.

Based on prior authorization data for 2023 in the commercial space, OSI found that some providers with more generalized medical practices and low volume prior authorization requests were unable to meet the 90% threshold even when their prior authorization requests were generally appropriate.

ADMINISTRATIVE IMPLICATIONS
None.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None.

TECHNICAL ISSUES
None.

OTHER SUBSTANTIVE ISSUES
None.

ALTERNATIVES
Line 10 page 2: (2) "evaluation period" means a six-month period beginning each January and each June; (This language is unclear. If one period begins in January and the next in June, the month of June would be included in both evaluation periods, which may not be the intent. Clarification may be needed as to whether the second evaluation period should instead begin in July to avoid overlap and ensure clean data measurement)

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
According to KFF Poll, People View Prior Authorization as Greatest Burden in Navigating the Health System. It also creates excessive administrative burdens for providers. Not enacting this bill will keep status quo.

AMENDMENTS

Carving out an exemption for certain provider types and allowing a lower threshold may allow more practitioners to qualify for the exemption and help reduce administrative burdens across the board.