

SENATE TAX, BUSINESS AND TRANSPORTATION  
COMMITTEE SUBSTITUTE FOR  
SENATE HEALTH AND PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR  
SENATE BILL 20

**57TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2026**

AN ACT

RELATING TO INSURANCE; APPLYING THE REQUIREMENTS OF THE PRIOR  
AUTHORIZATION ACT TO PHARMACY BENEFITS MANAGERS CONTRACTED WITH  
ENTITIES SUBJECT TO THE HEALTH CARE PURCHASING ACT; PROHIBITING  
PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTION DRUGS PRESCRIBED  
TO TREAT SERIOUS MENTAL ILLNESS; LIMITING PRIOR AUTHORIZATION  
FOR DRUGS THAT TREAT CHRONIC HEALTH CONDITIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

**SECTION 1.** Section 59A-22B-2 NMSA 1978 (being Laws 2019,  
Chapter 187, Section 4, as amended) is amended to read:

"59A-22B-2. DEFINITIONS.--As used in the Prior  
Authorization Act:

A. "adjudicate" means to approve or deny a request  
for prior authorization;

B. "auto-adjudicate" means to use technology and

1 automation to make a near-real-time determination to approve,  
2 deny or pend a request for prior authorization;

3 C. "chronic health condition" means a condition  
4 that lasts one or more years and requires ongoing medical  
5 attention or limits activities of daily living;

6 D. "chronic maintenance drug" means a medication  
7 approved by the federal food and drug administration to be  
8 taken regularly for the treatment of chronic health conditions;

9 [~~G.~~] E. "covered person" means an individual who is  
10 insured under a health benefits plan;

11 [~~D.~~] F. "emergency care" means medical care,  
12 pharmaceutical benefits or related benefits to a covered person  
13 after the sudden onset of what reasonably appears to be a  
14 medical condition that manifests itself by symptoms of  
15 sufficient severity, including severe pain, that the absence of  
16 immediate medical attention could be reasonably expected by a  
17 reasonable layperson to result in jeopardy to a person's  
18 health, serious impairment of bodily functions, serious  
19 dysfunction of a bodily organ or part or disfigurement to a  
20 person;

21 [~~E.~~] G. "health benefits plan" means a policy,  
22 contract, certificate or agreement, entered into, offered or  
23 issued by a health insurer to provide, deliver, arrange for,  
24 pay for or reimburse any of the costs of medical care,  
25 pharmaceutical benefits or related benefits;

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1           ~~[F.]~~ H. "health care professional" means an  
2 individual who is licensed or otherwise authorized by the state  
3 to provide health care services;

4           ~~[G.]~~ I. "health care provider" means a health care  
5 professional, corporation, organization, facility or  
6 institution licensed or otherwise authorized by the state to  
7 provide health care services;

8           ~~[H.]~~ J. "health insurer" means a health maintenance  
9 organization, nonprofit health care plan, provider service  
10 network, medicaid managed care organization or third-party  
11 payer or its agent;

12           ~~[I.]~~ K. "medical care, pharmaceutical benefits or  
13 related benefits" means medical, behavioral, hospital,  
14 surgical, physical rehabilitation and home health services, and  
15 includes pharmaceuticals, durable medical equipment,  
16 prosthetics, orthotics and supplies;

17           ~~[J.]~~ L. "medical necessity" means health care  
18 services determined by a health care provider, in consultation  
19 with the health insurer, to be appropriate or necessary  
20 according to:

21                   (1) applicable, generally accepted principles  
22 and practices of good medical care;

23                   (2) practice guidelines developed by the  
24 federal government or national or professional medical  
25 societies, boards or associations; or

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1 (3) applicable clinical protocols or practice  
2 guidelines developed by the health insurer consistent with  
3 federal, national and professional practice guidelines, which  
4 shall apply to the diagnosis, direct care and treatment of a  
5 physical or behavioral health condition, illness, injury or  
6 disease;

7 [~~K.~~] M. "medical peer review" means review by a  
8 health care professional from the same or similar practice  
9 specialty that typically manages the medical condition,  
10 procedure or treatment under review for prior authorization;

11 [~~L.~~] N. "off-label" means a federal food and drug  
12 administration-approved medication that does not have a federal  
13 food and drug administration-approved indication for a specific  
14 condition or disease but is prescribed to a covered person  
15 because there is sufficient clinical evidence for a prescribing  
16 clinician to reasonably consider the medication to be medically  
17 necessary to treat the covered person's condition or disease;

18 [~~M.~~] O. "office" means the office of superintendent  
19 of insurance;

20 [~~N.~~] P. "pend" means to hold a prior authorization  
21 request for further clinical review;

22 [~~O.~~] Q. "pharmacy benefits manager" means ~~[an agent~~  
23 ~~responsible for handling prescription drug benefits for a~~  
24 ~~health insurer]~~ a person licensed by the superintendent as a  
25 pharmacy benefits manager pursuant to the provisions of the

1 Pharmacy Benefits Manager Regulation Act that has a direct  
 2 contract with an entity subject to the Health Care Purchasing  
 3 Act;

4 [P-] R. "prior authorization" means a voluntary or  
 5 mandatory pre-service determination, including a recommended  
 6 clinical review, that a health insurer makes regarding a  
 7 covered person's eligibility for health care services, based on  
 8 medical necessity, the appropriateness of the site of services  
 9 and the terms of the covered person's health benefits plan;  
 10 [~~and~~

11 [Q-] S. "rare disease or condition" means a disease  
 12 or condition that affects fewer than two hundred thousand  
 13 people in the United States; and

14 T. "serious mental illness" means a mental  
 15 condition that significantly impairs daily functioning and  
 16 requires comprehensive treatment. "Serious mental illness"  
 17 includes major depression, schizophrenia, schizoaffective  
 18 disorder, bipolar disorder, obsessive-compulsive disorder,  
 19 panic disorder, posttraumatic stress disorder and borderline  
 20 personality disorder."

21 **SECTION 2.** Section 59A-22B-4 NMSA 1978 (being Laws 2019,  
 22 Chapter 187, Section 6) is amended to read:

23 "59A-22B-4. DUTIES OF OFFICE--PRESCRIBING PENALTIES.--

24 A. The office shall standardize and streamline the  
 25 prior authorization process across all health insurers.

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1           B. On or before September 1, 2019, the office  
2 shall, in collaboration with health insurers and health care  
3 providers, promulgate a uniform prior authorization form for  
4 medical care, pharmaceutical benefits or related benefits to be  
5 used by every health insurer and health care provider after  
6 January 1, 2020; provided that the uniform prior authorization  
7 form shall conform to the requirements established for medicare  
8 and medicaid medical and pharmacy prior authorization requests.

9           C. The office shall maintain a log of complaints  
10 against health insurers for failure to comply with the Prior  
11 Authorization Act. After two warnings issued by the  
12 superintendent of insurance, the office may levy a fine of not  
13 more than five thousand dollars (\$5,000) on a health insurer  
14 that fails to comply with the provisions of the Prior  
15 Authorization Act.

16           D. By September 1, 2019, and each September 1  
17 thereafter, the office shall provide an annual written report  
18 to the governor and the legislature to include, at a minimum:

19                   (1) prior authorization data for each health  
20 insurer and pharmacy benefits manager individually and for  
21 health insurers collectively;

22                   (2) the number and nature of complaints  
23 against individual health insurers and pharmacy benefits  
24 managers for failure to follow the Prior Authorization Act; and

25                   (3) actions taken by the office, including the

1 imposition of fines, against individual health insurers and  
2 pharmacy benefits managers to enforce compliance with the Prior  
3 Authorization Act.

4 E. The annual written report shall be posted on the  
5 office's website."

6 SECTION 3. Section 59A-22B-5 NMSA 1978 (being Laws 2019,  
7 Chapter 187, Section 7, as amended) is amended to read:

8 "59A-22B-5. PRIOR AUTHORIZATION REQUIREMENTS.--

9 A. A health insurer or pharmacy benefits manager  
10 that offers prior authorization shall:

11 (1) use the uniform prior authorization forms  
12 developed by the office for medical care, for pharmaceutical  
13 benefits or related benefits pursuant to Section 59A-22B-4 NMSA  
14 1978 and for prescription drugs pursuant to Section 59A-2-9.8  
15 NMSA 1978;

16 (2) establish and maintain an electronic  
17 portal system for:

18 (a) the secure electronic transmission  
19 of prior authorization requests on a twenty-four-hour, seven-  
20 day-a-week basis, for medical care, pharmaceutical benefits or  
21 related benefits; and

22 (b) auto-adjudication of prior  
23 authorization requests;

24 (3) provide an electronic receipt to the  
25 health care provider and assign a tracking number to the health

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1 care provider for the health care provider's use in tracking  
2 the status of the prior authorization request, regardless of  
3 whether or not the request is tracked electronically, through a  
4 call center or by facsimile;

5 (4) auto-adjudicate all electronically  
6 transmitted prior authorization requests to approve or pend a  
7 request for benefits; and

8 (5) accept requests for medical care,  
9 pharmaceutical benefits or related benefits that are not  
10 electronically transmitted.

11 B. Prior authorization shall be deemed granted for  
12 prescription drug determinations not made within three business  
13 days, and for all other determinations not made within seven  
14 days; provided that:

15 (1) an adjudication shall be made within  
16 twenty-four hours, or shall be deemed granted if not made  
17 within twenty-four hours, when a covered person's health care  
18 professional requests an expedited prior authorization and  
19 submits to the health insurer or pharmacy benefits manager a  
20 statement that, in the health care professional's opinion that  
21 is based on reasonable medical probability, delay in the  
22 treatment for which prior authorization is requested could:

23 (a) seriously jeopardize the covered  
24 person's life or overall health;

25 (b) affect the covered person's ability

1 to regain maximum function; or

2 (c) subject the covered person to severe  
3 and intolerable pain; and

4 (2) the adjudication time line shall commence  
5 only when the health insurer or pharmacy benefits manager  
6 receives all necessary and relevant documentation supporting  
7 the prior authorization request.

8 C. [~~After December 31, 2020~~] An insurer or a  
9 pharmacy benefits manager may automatically deny a covered  
10 person's prior authorization request that is electronically  
11 submitted and that relates to a prescription drug that is not  
12 on the covered person's health benefits plan formulary;  
13 provided that the insurer or pharmacy benefits manager shall  
14 accompany the denial with a list of alternative drugs that are  
15 on the covered person's health benefits plan formulary.

16 D. Upon denial of a covered person's prior  
17 authorization request based on a finding that a prescription  
18 drug is not on the covered person's health benefits plan  
19 formulary, a health insurer or pharmacy benefits manager shall  
20 notify the person of the denial and include in a conspicuous  
21 manner information regarding the person's right to initiate a  
22 drug formulary exception request and the process to file a  
23 request for an exception to the denial.

24 E. An auto-adjudicated prior authorization request  
25 based on medical necessity that is pended or denied shall be

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1 reviewed by a health care professional who has knowledge or  
2 consults with a specialist who has knowledge of the medical  
3 condition or disease of the covered person for whom the  
4 authorization is requested. The health care professional shall  
5 make a final determination of the request. If the request is  
6 denied after review by a health care professional, notice of  
7 the denial shall be provided to the covered person and covered  
8 person's provider with the grounds for the denial and a notice  
9 of the right to appeal and describing the process to file an  
10 appeal.

11 F. A health insurer or pharmacy benefits manager  
12 shall establish a process by which a health care provider or  
13 covered person may initiate an electronic appeal of a denial of  
14 a prior authorization request.

15 G. A health insurer or pharmacy benefits manager  
16 shall have in place policies and procedures for annual review  
17 of its prior authorization practices to validate that the prior  
18 authorization requirements advance the principles of lower cost  
19 and improved quality, safety and service.

20 H. The office shall establish by rule protocols and  
21 criteria pursuant to which a covered person or a covered  
22 person's health care professional may request expedited  
23 independent review of an expedited prior authorization request  
24 made pursuant to Subsection B of this section following medical  
25 peer review of a prior authorization request pursuant to the

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

1 Prior Authorization Act."

2 SECTION 4. Section 59A-22B-8 NMSA 1978 (being Laws 2023,  
3 Chapter 114, Section 13, as amended) is amended to read:

4 "59A-22B-8. PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS OR  
5 STEP THERAPY FOR CERTAIN CONDITIONS PROHIBITED.--

6 A. Coverage for medication approved by the federal  
7 food and drug administration that is prescribed for the  
8 treatment of an autoimmune disorder, cancer, a rare disease or  
9 condition, a serious mental illness or a substance use  
10 disorder, pursuant to a medical necessity determination made by  
11 a health care professional from the same or similar practice  
12 specialty that typically manages the medical condition,  
13 procedure or treatment under review, shall not be subject to  
14 prior authorization, except in cases in which a biosimilar,  
15 interchangeable biologic or generic version is available.  
16 Medical necessity determinations shall be automatically  
17 approved within [~~seven~~] three business days for standard  
18 determinations and twenty-four hours for emergency  
19 determinations when a delay in treatment could:

20 (1) seriously jeopardize a covered person's  
21 life or overall health;

22 (2) affect a covered person's ability to  
23 regain maximum function; or

24 (3) subject a covered person to severe and  
25 intolerable pain.

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1           B. A health insurer or pharmacy benefits manager  
2 shall not impose step therapy requirements before authorizing  
3 coverage for medication approved by the federal food and drug  
4 administration that is prescribed for the treatment of an  
5 autoimmune disorder, cancer, a serious mental illness or a  
6 substance use disorder, pursuant to a medical necessity  
7 determination made by a health care professional from the same  
8 or similar practice specialty that typically manages the  
9 medical condition, procedure or treatment under review, except  
10 in cases in which a biosimilar, interchangeable biologic or  
11 generic version is available. Prior authorization or step  
12 therapy requirements may be used when necessary for the  
13 clinical safety of a person with a serious mental illness if  
14 the person is:

- 15                   (1) younger than eighteen years of age; or
- 16                   (2) residing in an institutionalized setting.

17           C. A health insurer or pharmacy benefits manager  
18 shall not impose step therapy requirements before authorizing  
19 coverage for an off-label medication that is prescribed for the  
20 treatment of a rare disease or condition, pursuant to a medical  
21 necessity determination made by a health care professional from  
22 the same or similar practice specialty that typically manages  
23 the medical condition, procedure or treatment under review,  
24 except in cases in which a biosimilar, interchangeable biologic  
25 or generic version is available. Medical necessity

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1 determinations shall be automatically approved within [~~seven~~]  
2 three business days for standard determinations and twenty-four  
3 hours for emergency determinations when a delay in treatment  
4 could:

5 (1) seriously jeopardize a covered person's  
6 life or overall health;

7 (2) affect a covered person's ability to  
8 regain maximum function; or

9 (3) subject a covered person to severe and  
10 intolerable pain.

11 D. After a health insurer or pharmacy benefits  
12 manager approves prior authorization for a chronic maintenance  
13 drug, the health insurer or pharmacy benefits manager shall not  
14 require subsequent prior authorization more than once every  
15 three years, unless:

16 (1) the prior authorization was obtained based  
17 on fraud or misrepresentation;

18 (2) final action by the federal food and drug  
19 administration, other regulatory agencies or the drug  
20 manufacturer:

21 (a) removes the chronic maintenance drug  
22 from the market;

23 (b) limits use of the chronic  
24 maintenance drug in a manner that affects the prior  
25 authorization; or

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1                                    (c) communicates a patient safety issue  
2 that would affect the prior authorization;

3                                    (3) a generic equivalent or drug that is  
4 biosimilar to the chronic maintenance drug is added to the  
5 health insurer's or pharmacy benefits manager's drug formulary;  
6 or

7                                    (4) the prescription is written for drugs that  
8 may have a cosmetic use, including weight loss medications."

9                    SECTION 5. APPLICABILITY.--The provisions of this act  
10 apply to an individual or group policy, contract, certificate  
11 or agreement to provide, deliver, arrange for, pay for or  
12 reimburse any of the costs of medical care, pharmaceutical  
13 benefits or related benefits that is entered into, offered or  
14 issued by a health insurer or pharmacy benefits manager on or  
15 after January 1, 2027, pursuant to any of the following:

- 16                    A. Chapter 59A, Article 22 NMSA 1978;
- 17                    B. Chapter 59A, Article 23 NMSA 1978;
- 18                    C. the Health Maintenance Organization Law;
- 19                    D. the Nonprofit Health Care Plan Law; or
- 20                    E. the Health Care Purchasing Act.