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

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

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

conditions;

E. "covered person" means an individual who is insured under a health benefits plan;

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

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

H. "health care professional" means an individual who is licensed or otherwise authorized by the state to provide health care services;

I. "health care provider" means a health care professional, corporation, organization, facility or institution licensed or otherwise authorized by the state to provide health care services;

J. "health insurer" means a health maintenance organization, nonprofit health care plan, provider service network, medicaid managed care organization or third-party payer or its agent;

K. "medical care, pharmaceutical benefits or related benefits" means medical, behavioral, hospital, surgical, physical rehabilitation and home health services, and includes pharmaceuticals, durable medical equipment, prosthetics, orthotics and supplies;

L. "medical necessity" means health care services determined by a health care provider, in consultation with the health insurer, to be appropriate or necessary according to:

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

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

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

M. "medical peer review" means review by a health

care professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review for prior authorization;

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

O. "office" means the office of superintendent of insurance;

P. "pend" means to hold a prior authorization request for further clinical review;

Q. "pharmacy benefits manager" means a person licensed by the superintendent as a pharmacy benefits manager pursuant to the provisions of the Pharmacy Benefits Manager Regulation Act that has a direct contract with an entity subject to the Health Care Purchasing Act;

R. "prior authorization" means a voluntary or mandatory pre-service determination, including a recommended clinical review, that a health insurer makes regarding a covered person's eligibility for health care services, based on medical necessity, the appropriateness of the site of

services and the terms of the covered person's health benefits plan;

S. "rare disease or condition" means a disease or condition that affects fewer than two hundred thousand people in the United States; and

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

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

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

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

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

prior authorization requests.

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

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

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

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

(3) actions taken by the office, including the imposition of fines, against individual health insurers and pharmacy benefits managers to enforce compliance with the Prior Authorization Act.

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

SECTION 3. Section 59A-22B-5 NMSA 1978 (being Laws

2019, Chapter 187, Section 7, as amended) is amended to read:

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

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

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

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

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

(b) auto-adjudication of prior authorization requests;

(3) provide an electronic receipt to the health care provider and assign a tracking number to the health care provider for the health care provider's use in tracking the status of the prior authorization request, regardless of whether or not the request is tracked electronically, through a call center or by facsimile;

(4) auto-adjudicate all electronically transmitted prior authorization requests to approve or pend a

request for benefits; and

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

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

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

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

(b) affect the covered person's ability to regain maximum function; or

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

(2) the adjudication time line shall commence only when the health insurer or pharmacy benefits manager receives all necessary and relevant documentation

supporting the prior authorization request.

C. An insurer or a pharmacy benefits manager may automatically deny a covered person's prior authorization request that is electronically submitted and that relates to a prescription drug that is not on the covered person's health benefits plan formulary; provided that the insurer or pharmacy benefits manager shall accompany the denial with a list of alternative drugs that are on the covered person's health benefits plan formulary.

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

E. An auto-adjudicated prior authorization request based on medical necessity that is pended or denied shall be reviewed by a health care professional who has knowledge or consults with a specialist who has knowledge of the medical condition or disease of the covered person for whom the authorization is requested. The health care professional shall make a final determination of the request. If the request is denied after review by a health care professional,

notice of the denial shall be provided to the covered person and covered person's provider with the grounds for the denial and a notice of the right to appeal and describing the process to file an appeal.

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

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

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

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

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

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

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

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

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

B. A health insurer or pharmacy benefits manager shall not impose step therapy requirements before authorizing coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of an autoimmune disorder, cancer, a serious mental illness or a

substance use disorder, pursuant to a medical necessity determination made by a health care professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review, except in cases in which a biosimilar, interchangeable biologic or generic version is available. Prior authorization or step therapy requirements may be used when necessary for the clinical safety of a person with a serious mental illness if the person is:

(1) younger than eighteen years of age; or

(2) residing in an institutionalized setting.

C. A health insurer or pharmacy benefits manager shall not impose step therapy requirements before authorizing coverage for an off-label medication that is prescribed for the treatment of a rare disease or condition, pursuant to a medical necessity determination made by a health care professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review, except in cases in which a biosimilar, interchangeable biologic or generic version is available. Medical necessity determinations shall be automatically approved within three business days for standard determinations and twenty-four hours for emergency determinations when a delay in treatment could:

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

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

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

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

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

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

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

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

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

(3) a generic equivalent or drug that is biosimilar to the chronic maintenance drug is added to the

health insurer's or pharmacy benefits manager's drug formulary; or

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

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

A. Chapter 59A, Article 22 NMSA 1978;

B. Chapter 59A, Article 23 NMSA 1978;

C. the Health Maintenance Organization Law;

D. the Nonprofit Health Care Plan Law; or

E. the Health Care Purchasing Act.