AN ACT

RELATING TO HEALTH INSURANCE; ENACTING THE PRIOR AUTHORIZATION ACT; REQUIRING THE OFFICE OF SUPERINTENDENT OF INSURANCE TO STANDARDIZE AND STREAMLINE THE PRIOR AUTHORIZATION PROCESS FOR NON-EMERGENCY MEDICAL CARE, PHARMACEUTICAL BENEFITS OR RELATED BENEFITS; IMPOSING REQUIREMENTS ON HEALTH INSURERS WITH RESPECT TO PRIOR AUTHORIZATION; REQUIRING THE OFFICE OF SUPERINTENDENT OF INSURANCE TO REPORT DATA ON PRIOR AUTHORIZATION; PROHIBITING CONTRACTUAL ARRANGEMENTS THAT VIOLATE THE PRIOR AUTHORIZATION ACT; ENACTING NEW SECTIONS OF THE HEALTH CARE PURCHASING ACT AND THE PUBLIC ASSISTANCE ACT TO PROVIDE FOR APPLICABILITY.

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

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"PRIOR AUTHORIZATION ACT.--Benefits administrators of group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act are subject to and shall comply with the Prior Authorization Act."

SECTION 2. A new section of the Public Assistance Act is enacted to read:

"MEDICAL ASSISTANCE--MANAGED CARE ORGANIZATION CONTRACTS--APPLICABILITY OF PRIOR AUTHORIZATION ACT.--The

secretary shall ensure that contracts with managed care organizations to provide medical assistance to medicaid recipients are subject to and comply with the Prior Authorization Act."

SECTION 3. SHORT TITLE.--Sections 3 through 7 of this act may be cited as the "Prior Authorization Act".

SECTION 4. 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. "covered person" means an individual who is insured under a health benefits plan;

D. "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;

E. "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;

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

G. "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;

H. "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;

I. "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;

J. "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;

K. "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;

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

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

N. "pharmacy benefits manager" means an agent responsible for handling prescription drug benefits for a health insurer; and

O. "prior authorization" means a pre-service determination 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.

SECTION 5. EMERGENCY CARE.--Emergency care provided to a covered person, regardless of where the emergency care is provided, shall not be subject to prior authorization requirements.

SECTION 6. 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 individually and for health insurers collectively;

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

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

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

SECTION 7. PRIOR AUTHORIZATION REQUIREMENTS.--

A. A health insurer that requires 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 6 of this 2019 act 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) by January 1, 2021, 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) by January 1, 2021, 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 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 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 receives all necessary and relevant documentation supporting the prior authorization request.

C. After December 31, 2020, an insurer 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 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 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 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 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 of superintendent of insurance 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 8. APPLICABILITY.--The provisions of the Prior Authorization 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 on or after July 1, 2019, 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.