F I S C A L I M P A C T R E P O R T

SPONSOR SJC **ORIGINAL DATE** 2/03/19 **LAST UPDATED** 3/12/19 **HB**

SHORT TITLE Health Insurance Prior Authorization Act **SB** CS/CS188/SPACS/ SJCS/aHHHC/aHFl

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$240.0*	$240.0*	$480.0*	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases) *These amounts do not include potential increases in costs for IBAC agencies. See discussion under Fiscal Implications.

Relates to numerous other current bills enumerated below.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
Human Services Department (HSD)
Retiree Health Care Authority (RHCA)

SUMMARY

Synopsis of HFl#1 Amendment

The House Floor #1 Amendment makes a change to the HHHC amendment, removing the requirement that the health care professional evaluating a covered person's denial for prior authorization (prior auth) be of the same specialty as the prescriber, indicating now that the evaluating medical professional must be knowledgeable about the disease or condition for which the prior auth was requested.

Synopsis of HHHC Amendment

The House Health and Human Services Committee amendment to the Senate Judiciary Committee Substitute to Senate Public Affairs Committee Substitute for Senate Bill 188 makes the following changes:

1) Specify the required electronic portal be able to automatically approve or pend requests for benefits.
2) Add three new subsections of requirements regarding prior authorizations:

a. If a request for prior authorization is denied, the covered person must be notified and informed of the process of appealing the denial;
b. Auto-adjudicated denials must be reviewed by a medical of the same medical specialty as the prescriber, who would make a final decision, though the covered person would still be informed of the decision and of the right to appeal it;
c. Health providers would be given an electronic method of appeal a prior auth denial.

3) Allow covered persons, as well as their healthcare providers, to be able to request expedited review of a prior auth request pursuant to Section B of the bill, which deals with the time period during which a prior auth request must be adjudicated.

SUMMARY

Synopsis of Original Bill

The Senate Judiciary Committee substitute for the Senate Public Affairs Committee substitute for Senate Bill 188 would enact a Prior Authorization Act to ameliorate the effects that prior authorization requirements have on patients and providers. In so doing, it makes new requirements on health insurance providers.

Prior authorization is a method used to deny coverage for a drug or medical or surgical procedure if the provider has not requested and been granted the insurance company's or pharmacy benefit manager (PBM) approval in advance. The necessity of obtaining prior authorization for many patients and many procedures and prescriptions is often cited by providers as among the factors weighing on the time they might spend with patients, and patients are often frustrated by the time and delays they encounter.

The act's eight sections are summarized in the table below:

Section	Summary of Provisions
1	States that group health coverage administrators, including of self-insurance plans must comply with the act's provisions.
2	Medicaid (Centennial Care) providers must comply with the act.
3	Short title given.
4	New definitions of terms. "Pharmaceutical benefits" has been added as a component of a "health benefits plan," as well as in a number of other locations in the bill. "Emergency care" means medical care, pharmaceutical care, or related benefits that a reasonable person would believe necessary to prevent death, serious effects on body function, or disfigurement.
5	Emergency care would nowhere be subject to prior authorization
6	OSI would promulgate a common prior auth form and standardize it use and prior authorization practice among health insurers to include a list of medications not requiring prior authorization. Some providers would be exempted from prior authorization requirements on certain prescriptions or procedures if they showed low rates of denial in certain areas of their practices. OSI, along with insurers and providers, would adopt clinical guidelines for 200 clinical practice guidelines for common conditions and would publicize those guidelines and require no prior authorization for following their dictates. OSI would create a list of providers willing to review denials of prior authorization on request. OSI would make an

	annual written report of prior authorization data and complaints for each insurer as well as actions, including fines of up to $5,000, OSI had taken against each insurer.
7	Health insurers using prior authorization procedures would be required to have an always-available portal system for receiving prior authorization requests, which would, by July 1, 2020, allow for auto-adjudication and provide a receipt for requesting healthcare providers. Prior authorization would have to be granted or denied within 7 business days of the insurer receiving all necessary documentation, and within 24 hours if the healthcare provider felt that a longer delay would endanger the patient. Each health insurer would be required to have a process in place to annually review prior authorization procedures to be sure they were still serving their purposes of decreasing cost and increasing health. OSI would be required to set up an appeal process to be used by healthcare providers. After December 31, 2020, insurers could automatically deny an insured's electronic prior authorization request for a drug, as long as the insurer provided a list of covered alternative drugs.
8	The act is made applicable to all types of health insurance.

FISCAL IMPLICATIONS

The bill does not make an appropriation.

The Office of the Superintendent of Insurance would be tasked with developing regulations to apply to prior authorization and would have to oversee and police those regulations. OSI states the following regarding its costs:

> OSI currently has no staff capable of overseeing the development of these prior authorization protocol standardization requirements. OSI also does not have any staff available to collect the data and generate the reports required by this act. OSI also does not have sufficient staff to legal staff to issue required related regulations and to pursue the violations and enforcement action required by the act. OSI regulates eight major medical carriers for whom it would be required to ensure compliance with these standards. OSI also anticipates significant other staffing and contractual costs to develop these protocols, including additional needs for procurement staff. OSI projects a breakdown of the costs below:
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> - Data collection and analyst staffing for reporting - $150,000 salary plus benefits, 2 FTEs
> - Legal staff, for regulatory development and enforcement - $90,000 1 FTE attorney position.
> - Annual total = $240,000
> - Three year total = $720,000

If restrictions on prior authorization as mandated by this bill increased the cost of medical care given to consumers insured by Interagency Benefits Advisory Council agencies, the state's share of medical costs would also be increased by undetermined amounts. RHCA comments, "Senate Bill 188 limits the use of prior authorization, as a utilization management tool and requires a uniform set of procedures to administer the process. The fiscal impact to the New Mexico

Retiree Health Care Authority is difficult to estimate, however; according to our health plan partners at Blue Cross and Blue Shield (BCBSNM) - the potential cost drivers are the removal of prior authorization on over 200 diagnoses and a list of prescriptions drugs, as well as by the administrative burdens required to implement this prior authorization program required under the bill."

SIGNIFICANT ISSUES

As indicated in a report from the National Conference of Legislatures, drug costs are a major concern that states are addressing in many different ways, including through prior authorization of expensive medications. On the other hand, physician groups express concern about erosion of health care provider time through the intrusion of prior authorization requirements on their time (and resulting contributions to widespread provider "burnout," and patients' frustration about procedures and prescriptions denied and the time required of them to appeal those denials).

According to RHC:

> A consensus statement was developed by the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), American Medical Association (AMA), American Public Health Association (APHA), Blue Cross and Blue Shield Association and Medical Group Management Association (MGMA), which represents physicians, pharmacists, medical groups, hospitals and health plans. These groups partnered to identify opportunities to improve the prior authorization process with the goal of promoting safe, timely and affordable access to evidence-based care for patients. The statement cites the burdensome process, but it also suggests that there is a wide variation in medical practice and adherence to evidence based treatments.
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> These groups came to consensus and identified five areas where opportunities for improvement in prior authorization programs and processes, that once implemented, can achieve meaningful reform. The full list of recommendations can be found on the attached link: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf?_hsenc=p2ANqtz-8Tl2RfN1Wy7uFPD_gL7Ke-GquDrLCztQL3k5AjqFu73qzbqzoNlkYxjIYwB30YddTeHEse and include: selective application of prior authorization, prior authorization program review and volume adjustment, transparency and communication regarding prior authorization, continuity of patient care and automation to improve transparency and efficiency.

HSD notes that Centennial Care provider contracts would need to be revised to comply with provisions of this act.

> "SB188 would have significant performance implications for the Medicaid MCOs. The MCOs utilize the prior authorization processes to verify membership, verify benefit coverage, and to determine medical necessity and appropriateness. Determining medical necessity, in particular, can take time that may exceed the 24-hour turnaround time required in the bill. Deciding whether a prescription is medically necessary for each Medicaid beneficiary can require adequate clinical information and review and/or research of peer-reviewed medical literature. This information is sometimes not provided concurrent with the prior authorization request."

OSI has current standards in prior authorization of procedures and prescriptions. OSI states:

> OSI's current utilization review and prior authorization standards require the carriers to work with New Mexico providers to develop protocols. The current regulations also require insurers to provide timely access to utilization review staff to assist in the prior authorization process and make determinations. OSI requires insurance companies to file their utilization review and prior authorization review protocols with the agency for review and approval on an annual basis. OSI is in the process of updating its current regulations, and circulated a draft utilization review regulation to stakeholders for comment in November 2018. OSI anticipates having stakeholder meetings about these regulations after session. The newly proposed regulations include provisions requiring development of electronic prior authorization submission guidelines. These proposed regulations were developed pursuant to New Mexico's Patient Protection Act, which grants OSI significant authority to regulate insurance companies' utilization practices and prior authorization protocols. Much of this legislation has language in it that is better left to regulation.
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> **Internal Review Organizations** - The legislation also may duplicate OSI's current independent review processes. OSI's current grievance and appeals processes, issued under the Patient Protection Act, require insurers to send appeals for independent review organization review upon the request of an insured after first hearing an internal review. The timeline for turnaround in exigent cases for that review is 72 hours after the request for the independent review is initiated. In many cases, OSI requires carriers to complete this process in a more expeditious fashion. OSI does not believe that the duplicate process in this legislation is necessary, and may be difficult to administer, and may violate federal law and result in federal takeover of the state's grievance and appeals procedures. OSI's current federal grievance and appeals procedures were approved prior to use by CMS.

RELATED to numerous other bills that regulate prior authorization, surprise billing, and health insurance in a variety of ways:

HB 81	PHYSICAL REHAB COST SHARING LIMITS
HB 89	HEALTH COVERAGE FOR CONTRACEPTION
HB 207	SURPRISE BILLING PROTECTION ACT
SB 92	REGULATE PHARMACY BENEFITS MANAGER PRACTICES
SB 112	LIMITATIONS ON HEALTH COVERAGE AND CONTRACTS
SB 188	HEALTH INSURANCE PRIOR AUTHORIZATION ACT
*SB 309	INSURANCE ULTRASOUND AUTHORIZATIONS
SB 337	SURPRISE BILLING PROTECTION ACT

TECHNICAL ISSUES

In section 5, "emergency care" is not defined. It is unclear what definition of "emergency" would be used.

OSI makes the following additional points about changes that may be needed in the act:

- Mental Health Parity – The legislation requires OSI to develop prior authorization protocols for family practice, pediatric practice, and internal medicine. There is no requirement for application to behavioral health services. This likely will constitute a violation of the federal mental health parity and addiction equity act. To ensure compliance with that law, this legislation would likely need to be amended and additional funds would be required to ensure compliance and develop standards.

- Trade Practices and Fraud statute – This legislation has internal inconsistencies about application of the Trade Practices and Frauds Act. For example, the legislation applies the Insurance Code's Trade Practices Act, however has separate fines for insurance companies for certain violations of the Act.

- Enforcement – OSI does not have enforcement authority over plans covering public employees through the Health Care Purchasing Act, nor Managed Care Organization Contracts. This legislation's enforcement authority over those plans is unclear in this legislation.

ALTERNATIVES

A task force could be created to study a compromise measure that would mediate between insurer needs and provider and patient concerns and recommend compromise legislation.

OSI could be asked to develop regulations to accomplish some of the aims of the Prior Authorization Act.

LAC/gb/sb