LFC Requester:	Harry Rommel

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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(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: *02/20/2025*
Bill Number: *HB 461*

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

Sponsor: Doreen Gallegos, Meredith Dixon, Linda Serrato
Short Title: PRIOR AUTHORIZATION PROCESS EXEMPTIONS

Agency Name and Code Number: Office of Superintendent of Insurance - 440
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	**FY26**		
N/A	N/A	N/A	N/A

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
N/A	N/A	N/A	N/A	N/A

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	**N/A**	N/A	N/A	N/A	N/A	N/A

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: SB263, Prior Authorization Process Exemptions

Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

House Bill 461 (HB461) adds a new section to the Prior Authorization Act in the Insurance Code to require health insurers to establish procedures to grant exemptions from the health care insurer's prior authorization process for certain qualified health care professionals that submits an application for exemption. Exemption may be granted by the health care insurer if, during the established evaluation period prior to the application, at least ninety percent of the applicant's prior authorization requests for that service have been approved. The evaluation period is defined as a six-month period beginning each January and each June. The health care insurer must grant the exemption request within ten business days.

HB461 allows the health care insurer to evaluate once during each evaluation period the health care professional's exemption and the exemption may be rescinded if the health care insurer determines that less than ninety percent of the claims submitted by the professional would have met the applicable medical necessity criteria based upon a random sampling of between five to 20 claims. The health care insurer must notify the health care professional by written notice at least 25 days before the rescission takes effect. The bill also allows a health care insurer to determine that the health care professional has fraudulently or abusively used any exemption, the insurer may immediately and retroactively to the time of the first incident of fraud or abuse, rescind all exemptions upon written notice to the health care professional.

The health care professional has a right to an independent review determination regarding an adverse determination from the health care insurer to be conducted by an independent review organization within 30 days after the date the health care professional files a request for review. The health care insurer is obligated to pay for the independent review of the adverse determination and shall pay a reasonable fee for any copies of medical records or other documents requested and necessary for the conducting the independent review.

The bill requires the Superintendent of Insurance to promulgate rules to carry out the provisions in the bill by December 31, 2025.

FISCAL IMPLICATIONS

None.

SIGNIFICANT ISSUES

HB461 shifts the burden of tracking prior authorization requests and application for exemption status from insurance carriers to providers.

PERFORMANCE IMPLICATIONS

None.

ADMINISTRATIVE IMPLICATIONS

OSI will need to amend 13.10.31.12 NMAC, Evaluation of Prior Authorization Policy and Provider Performance section of its Prior Authorization Rule, which is incompatible with the proposed language in HB461. This will require analysis, revision, stakeholder engagement and rule hearing. This will also require a transition for providers who are exempt under the current prior authorization exemption rule to the new statute, if adopted.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

SB207 also amends a section of the Prior Authorization Act, Section to add classes of drugs to exempt them from prior authorization requirements.

SB263 amends a section of the Prior Authorization Act, using similar wording to HB461.

SB39 also amends the Authorization Act to exempt FDA approved medication for treatment of a rare disease or condition from prior authorizations or step therapy protocols.

TECHNICAL ISSUES

1. Page 2, line 11: If the six-month period is intended to be biannual, then it should read "each January and each July," instead of January and each June."
2. Page 4, line 3 provides for a review of a "random sample" of claims. A random sample may not be an accurate representation. Use of generally accepted auditing principles and practices as they apply to medical claims audit would be more appropriate.
3. The following references are inconsistent and list two different numbers for the same requirement:

   Page 2, lines 23-25: "no less than ninety percent of the health care professional's ten or more prior authorization requests";

   Page 4, lines 2-4: "based on a retrospective review of a random sample of not fewer than five but no more than twenty claims"

OTHER SUBSTANTIVE ISSUES

1. Page 3, line 15: An end date for the exemption should be included in the requirement since it's up to the provider to reapply for exemption after 6 months.
2. Page 4, line 3-4: If an insurer is evaluating a provider with more than 20 claims, how are the claims chosen? Without randomization, the data could be skewed by the insurer based on which claims the insurer chooses for the review. Also, the range of claims within the bill may be a sufficient sample size for some benefits, but not others.
3. Page 4, line 6: The term "twenty-five days" is not defined and can refer to calendar days or business days. Also, because this does not align with the month allowed for independent review, this term can leave the provider without recourse for a minimum of 5 days
4. Page 4, line 23: The term "Independent review organization" is not defined, and is relevant to assure there is not a conflict of interest with the insurer.
5. Page 5, line 4: "sample of claims" is not defined, and data can be skewed without a randomization process for choosing which claims are evaluated.
6. Page 5, line 15-16: If the records/documents are obtained by the Board of Osteopathic Medicine (who are also considered physicians), it doesn't make sense for the NM Medical Board to determine the fee.

ALTERNATIVES

A process consistent with the current Prior Authorization Rule, 13.10.31 NMAC, may be more beneficial for providers.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

1. Currently, as outlined in NMAC 13.10.31.12, insurers are required to review prior authorization requirements annually, which includes the approval rate for each covered benefit and selection of practitioners exempt from prior authorization requirements.
2. HB461, if implemented, would shift the burden of application for exemption to the practitioners.

3. If implemented, HB461 would also cut the time in half, from one year down to six months, that a provider is exempt from prior authorization requirements based on the evaluation period proposed HB461.

AMENDMENTS

Page 5, line 7 & 9: “person” should read as “health care provider”

Page 5, line 15 - 16: “New Mexico Medical Board” should read as “Physicians Licensing Board”