LFC Requester:	Eric Chenier

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}

Check all that apply:
Original X **Amendment** ____
Correction ___ **Substitute** ____

Date 2-4-2025
Bill No: SB 263

Sponsor: Sen. Martin Hickey
Short Title: Prior Authorization Process Exemptions

Agency Name and Code Number: Regulation and Licensing Department - 420
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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 Expenditure 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:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: Senate Bill 263 (SB263)

SB263 requires healthcare insurers (insurers) to establish procedures to grant exemptions from their prior authorization process requirement for certain healthcare providers (providers.) SB263 prescribes the criteria for granting such exemptions and the process for independent review of rescinded exemptions.

A provider may apply to an insurer for an exemption from its prior authorization requirement for a healthcare service. That exemption shall be granted if, in the evaluation period prior to the request, at least ninety percent (90%) of the provider's prior authorization requests for that service have been approved upon initial submission or after appeal. "Evaluation period" is defined as a six-month period beginning each January and June. An insurer must approve or deny the exemption request within ten (10) business days.

Once, during each evaluation period, an insurer may determine whether to continue or rescind a provider's exemption. An exemption shall not be rescinded unless the insurer: (1) determines that less than 90% of the claims submitted by the provider would have met the applicable medical necessity criteria, based on a retrospective review of a random sample of not less than five and not more than 20 claims; and (2) provides the healthcare provider with written notice at least twenty-five (25) days before the rescission would take effect.

If an insurer rescinds a prior authorization exemption, the provider has the right to request an independent review of the determination. The insurer may not require a provider to engage in an internal appeal process before requesting an independent review.

The independent review, if requested by the provider, will be conducted by the following process: (1) the independent review organization shall complete a review of an adverse decision within thirty (30) days after a request is filed; (2) a provider may request that the independent reviewer review another sample of claims than those reviewed by the insurer; (3) the review shall be conducted by a person licensed to practice medicine in New Mexico, and, if the provider is a physician, the review shall be made by a person licensed to practice in the same or similar specialty; (4) the insurer shall pay for an independent review of a decision to rescind as well as for any copies of records necessary to conduct the review; (5) both parties are bound by the independent review organization's decisions; and (6) if the review overturns the insurer's determination to rescind a prior authorization exemption, the insurer shall not attempt to rescind

that exemption again until the beginning of the next evaluation period.

If the independent reviewer affirms the insurer's determination to rescind, the insurer shall not retroactively deny any prior authorizations granted on the basis of a rescission of an exemption, and the provider is eligible to apply for a new exemption during the following evaluation period.

The effective date of the legislation is January 1, 2026.

FISCAL IMPLICATIONS
The Regulation and Licensing Department (RLD) does not anticipate any significant fiscal impact from the enactment of SB263.

SIGNIFICANT ISSUES
It does not appear that a healthcare provider has access to an independent review if they are denied the exemption initially-only if denied later, after receiving the initial exemption. Without recourse to review a denial process of this exemption, the denial could be abused by healthcare insurers.

PERFORMANCE IMPLICATIONS

ADMINISTRATIVE IMPLICATIONS

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

TECHNICAL ISSUES

OTHER SUBSTANTIVE ISSUES

ALTERNATIVES

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

AMENDMENTS