HOUSE BILL 461

57TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2025

INTRODUCED BY

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This document may incorporate amendments proposed by a committee, but not yet adopted, as well as amendments that have been adopted during the current legislative session. The document is a tool to show amendments in context and cannot be used for the purpose of adding amendments to legislation.

AN ACT

RELATING TO INSURANCE; ENACTING A NEW SECTION OF THE PRIOR AUTHORIZATION ACT TO REQUIRE HEALTH INSURERS TO ESTABLISH PROCEDURES TO GRANT EXEMPTIONS FROM THEIR PRIOR AUTHORIZATION PROCESS FOR HEALTH CARE PROFESSIONALS THAT MEET CERTAIN CRITERIA.

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

SECTION 1. Section 59A-22B-1 NMSA 1978 (being Laws 2019, Chapter 187, Section 3) is amended to read:

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = →bold, blue, highlight←
delete = →bold, red, highlight, ~~strikethrough~~←

"59A-22B-1. SHORT TITLE.--[~~Sections 3 through 7 of this act~~] Chapter 59A, Article 22B NMSA 1978 may be cited as the "Prior Authorization Act"."

SECTION 2. A new section of the Prior Authorization Act is enacted to read:

"[NEW MATERIAL] PROCESS FOR GRANTING EXEMPTIONS FROM PRIOR AUTHORIZATION PROCESS CREATED--APPLICATIONS--ELIGIBILITY--RESCISSION--INDEPENDENT REVIEW.--

A. For purposes of this section:

(1) "abuse" means health care professional practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the health insurer or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care;

(2) "evaluation period" means a six-month period beginning each January and each June; and

(3) "fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or another person and includes any act that constitutes fraud under applicable federal or state law.

B. No sooner than thirty days after the end of each evaluation period, a participating health care professional may apply to a health insurer for an exemption from its prior

authorization process, including a recommended clinical review, for outpatient health care services. HHHC→"Outpatient health care services" does not include pharmaceutical services, prescription drug products or supplies.←HHHC A health insurer shall grant the exemption request if, in the evaluation period prior to the exemption request, no less than ninety percent of the health care professional's ten or more prior authorization requests for that outpatient health care service have been approved upon initial submission or after appeal.

C. A health insurer shall provide a written approval or denial of the prior authorization exemption request no later than ten business days after receipt of the request.

D. When a health care professional's prior authorization exemption request is denied, a health insurer shall provide an explanation for the denial, including data, that sufficiently demonstrates how the request failed to meet the criteria established pursuant to Subsection B of this section.

E. When a health care professional's prior authorization exemption request is approved, a health insurer shall provide the health care professional with information regarding the rights and obligations of the parties, including the effective date of the prior authorization exemption.

F. Once during each evaluation period, except as provided for in Subsection H of this section, a health insurer

may determine whether to continue or rescind a health care professional's prior authorization exemption.

G. Except as provided for in Subsection H of this section, a health insurer shall not rescind a health care professional's prior authorization exemption unless the health insurer:

(1) determines that less than ninety percent of the claims submitted by the health care professional during the previous evaluation period would have met the applicable medical necessity criteria, based on a retrospective review of a random sample of not fewer than five but no more than twenty claims; and

(2) provides the health care professional with written notice not less than twenty-five days before the rescission is to take effect, including an explanation and the sample information used to make the determination.

H. If a health insurer determines that a health care professional has fraudulently or abusively used any exemption, the health 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, including an explanation and sample information used to make the determination.

I. A health care professional has a right to a request an independent review of the determination to rescind a

prior authorization exemption.

J. A health insurer shall not require a health care professional to engage in an internal appeal process before requesting an independent review of the determination to rescind a prior authorization exemption.

K. An independent review organization shall complete a review of an adverse determination no later than thirty days after the date a health care professional files a request for the review.

L. A health care professional may request that the independent review organization conduct a review of another sample of claims using the process described in Subsection G of this section.

M. The independent review shall be conducted by a person licensed to practice medicine in this state. If the rescission applies to a physician, the determination shall be made by a person licensed to practice medicine in this state who practices in the same or similar specialty as the physician requesting the review.

N. The health insurer shall pay:

(1) for an independent review of the adverse determination; and

(2) a reasonable fee, determined by the New Mexico medical board, for any copies of medical records or other documents requested from the health care professional

that are necessary for conducting the independent review.

O. The parties shall be bound by an independent review organization's decision.

P. Except in the case of fraud or abuse, if an independent review organization overturns the health insurer's determination to rescind a prior authorization exemption, the health insurer shall not attempt to rescind that exemption until the beginning of the next evaluation period.

Q. If an independent review organization affirms the health insurer's determination to rescind a prior authorization exemption:

(1) except in the case of fraud or abuse, the health insurer shall not retroactively deny any prior authorization granted on the basis of a rescission of a prior authorization exemption; and

(2) a health care professional shall be eligible to apply for a new prior authorization exemption during the evaluation period that follows the evaluation period that formed the basis of the rescission.

R. If an independent review organization overturns the health insurer's determination to rescind a prior authorization exemption based on fraud or abuse, the health insurer shall reinstate the prior authorization exemption in no more than ten business days. If an independent review organization affirms the health insurer's determination to

rescind a prior authorization exemption based on fraud or abuse, the rescission shall remain in place as noticed by the health insurer to the health care professional.

S. The superintendent shall promulgate rules in accordance with this section no later than December 31, 2025."

SECTION 3. EFFECTIVE DATE.--The effective date of the provisions of this act is January 1, 2026.