FISCAL IMPACT REPORT

SPONSOR Jones/Thomson/Hernandez, J. **LAST UPDATED** **ORIGINAL DATE** 03/06/2025

SHORT TITLE Prior Authorization Requirement Changes **BILL NUMBER** House Bill 570

ANALYST Rommel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
OSI	$0	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Recurring	Other state funds
RHCA	$171.1	$2,155.2	$2,263.0	$4,589.3	Recurring	Other state funds
NMPSIA Benefit Fund	$4,500.0	$10,800.0-$22,900.0	$16,200.0-$29,300.0	$31,500.0-56,700.0	Recurring	Other state funds
Medicaid – State GF	$0.0	$2,155.2	$2,263.3	$4,589.5	Recurring	General Fund
Medicaid – Federal Funds	$0.0	$15,440.2	$15,440.2	$30,880.4	Recurring	Federal funds
State Health Benefits – GF	$0.0	$845.2	$845.2	$1,690.4	Recurring	General Fund
State Health Benefits – Member Impact	$0.0	$455.1	$845.2	$910.2	Recurring	Other state funds

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Relates to House Bill 461 and Senate Bills 39, 207, 263, 508

Sources of Information

LFC Files

Agency Analysis Received From
Office of the Superintendent of Insurance (OSI)
Retiree Health Care Authority (RHCA)
Public School Insurance Authority (NMPSIA)
Health Care Authority (HCA)

Agency Analysis was Solicited but Not Received From
List all agencies that failed to respond to a request for analysis.

SUMMARY

Synopsis of House Bill 570

House Bill (HB570) adds new sections to the Prior Authorization Act of the Insurance Code to prohibit prior authorization (PA) requirements for chemotherapy, dialysis, elder care, and home

health care services. HB570 also eliminates prior authorization and step therapy requirements for prescribed diabetes and high blood pressure medications approved by the Federal Drug Administration (FDA).

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns if enacted, or June 20, 2025.

FISCAL IMPLICATIONS

The Office of the Superintendent of Insurance (OSI) is unable to determine if the prior authorization and step-therapy prohibition will have an impact on premiums. Diabetes and high blood pressure medications are generally inexpensive; however, some market exclusive brand name drugs and second-line treatments can cost upwards of $1,000 for a 30-day supply, which may have a significant impact on premiums.

The Retiree Health Care Authority (RHCA) notes that the financial impact on the agency is expected to increase. The removal of prior authorization may lead to a rise in the utilization of chemotherapy, dialysis, elder care, and home health care services. If these services lead to higher overall treatment costs, particularly for complex or chronic conditions, this could lead to an increase in expenditure for RHCA.

The Public School Insurance Authority (NMPSIA) presents the budget impact of HB570 with several caveats:

> While the plan will incur costs, the short timeframe prevents NMPSIA from confidently predicting those costs with any degree of accuracy. The [budget impact] reflects estimated increases to the costs for the treatment of diabetes and high blood pressure only. There is still uncertainty in cost projections for the first part of the bill, relating to the removal of Prior Authorizations for Chemotherapy, Dialysis, Elder Care, or Home Health Care services due to the time limitation.
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> The bill takes away current safeguards by removing the PA process, which will increase utilization both in and out-of-network. Additionally, there is potential for an increase in members getting services that are not defined as a medical necessity for the condition. These instances will not be realized until after the claim has been paid by NMPSIA …. By combining all these factors—UM savings, rebate adjustments, and management costs for a custom formulary—NMPSIA concludes there will be a $31.5 - $56.7 million cost associated with the removal of UM for diabetes and high blood pressure. The final estimate reflects not just the cost of the treatment, but also the loss of potential savings from improved medication utilization, reduced costs from rebates, and any extra administrative fees.

The Health Care Authority (HCA) notes:

> For the management of diabetes there could be the potential for increased cost of utilization. There are several newer agents that can be used that are significantly more expensive (notably GLP-1, SGLT2 class of medications). This is compared to historical first-line agents like metformin which are much less costly. This legislation may switch utilization towards more expensive agents.
>
> The elimination of prior authorization and step therapy requirements for certain

prescription drugs, including GLP-1 medications and cholesterol treatments, is expected to have a significant fiscal impact on the State Health Benefits (SHB) Plan. Cholesterol medications, particularly PCSK9 inhibitors (e.g., Repatha, Praluent), are high-cost specialty drugs that would see increased demand if unrestricted access is granted.

Medicaid requires prior authorization for dialysis and home health services. It is possible that removal of prior authorization requirements could result in increased utilization.

SIGNIFICANT ISSUES

A 2023 US Health and Human Services Office of the Inspector General report expressed concern that some people enrolled in Medicaid managed care may not be receiving all medically necessary health care services intended to be covered based upon: (1) the high number and rates of denied prior authorization requests by some MCOs, (2) the limited oversight of prior authorization denials in most states, and (3) the limited access to external medical reviews.[1]

Four states (AR, TX, VT, and WV) have enacted comprehensive prior exemption laws while several other states, including New Mexico, have at least some requirements waiving prior authorizations for certain services (e.g., for certain prescription drugs).[2] Specifics vary from state to state, but in general they aim to reduce volume of prior authorization requirements, reduce patient care delays, increase public access to data, and improve transparency about which medications and procedures require prior authorization.

Currently, as outlined in New Mexico Administrative Code 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.

OSI notes HB570 provides a blanket prohibition on all prior authorization and step therapy requirements for high blood pressure and diabetes medications without addressing first-line therapy considerations or clinical practice guidelines. Prohibiting step therapy could lead to impudent prescribing practices such as adjunct or second line medications being prescribed as first-line options. In order to avoid increased risk of patient harm and avoid increased cost of care, it may be prudent to allow step therapy.

HCA comments:

There is a wide variety of services that would no longer have prior authorizations. Some of these services, including elder care services and dialysis services, can be covered under Medicare. In cases where individuals have both Medicare and Medicaid, a prior authorization is currently initiated to ensure Medicare is billed before Medicaid. As Medicare is a federal program, HCA would not have authority to remove Medicare prior authorization requirements. Services for individuals who are dually eligible for both Medicare and Medicaid would still require prior authorization for the service to be

[1] High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care https://oig.hhs.gov/documents/evaluation/3157/OEI-09-19-00350-Complete%20Report.pdf

[2] 2024 Prior Authorization State Law Chart | AMA https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf

Medicare reimbursable prior to sending a cross-over claim to Medicaid for remaining reimbursable costs.

ADMINISTRATIVE IMPLICATIONS

State Medicaid agencies and managed care organization (MCOs) have flexibility to determine the medications and services for which they will require prior authorization (§ 1902(a)(30) of the act and 42 CFR § 438.210). Examples of Medicaid services that commonly require prior authorization include non-emergency medical transportation, durable medical equipment, behavioral health services, inpatient hospital stays, inpatient and outpatient surgeries and procedures, rehabilitation services, and nursing facility services. States cannot impose prior authorization requirements for any screening services provided under the Early and Periodic Screening, Diagnostic, and Treatment benefit. States may prohibit prior authorization for some specific items, services or medications.[3]

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Relates to House Bill 461/aHHHC and Senate Bills 39, 207, 263, and 508, all of which amend the Prior Authorization Act.

- House Bill 461 establishes a process for granting exemptions from the prior authorization process for a healthcare services The bill as amended by House Health and Human Services restricts the scope of HB461 to prior authorization of outpatient medical procedures and does not address prior authorization for prescription drugs.
- Senate Bill 39 prohibits prior authorization and step therapy—the insurance plan practice of requiring patients to try less expensive medication first—for medications that are prescribed for on-label or off-label use for the treatment of rare disease or medical condition that affects fewer than 200 thousand people in the United States.
- Senate Bill 207 mandates coverage for medications prescribed for both on-label and off-label use. It also adds the treatment of rare diseases to the list of exceptions that do not require prior authorization, alongside autoimmune disorders, cancer, and substance use disorders. Additionally, drugs prescribed for on-label or off-label use in treating rare diseases cannot be subjected to step therapy.
- Senate Bill 263 adds a new section to Chapter 59A, Article 22B NMSA 1978, the Prior Authorization Act. The bill establishes a process for granting exemptions from the prior authorization process for a healthcare service.
- Senate Bill 508 eliminates cost sharing for certain sexual, reproductive and gender-affirming health care services and prohibits prior authorization for those services.

TECHNICAL ISSUES

OSI notes the term “elder care” is not defined in this bill or the Insurance Code, which creates ambiguity on what services and benefits would fall in the category as covered services. The preferred term is “older adult” rather than elder per American Psychological Association,

[3] Prior Authorization in Medicaid - https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf

American Medical Association, and Gerontological Society of America.

OTHER SUBSTANTIVE ISSUES

59A-22B-8 NMSA 1978 addresses both prior authorization for prescription drugs and step therapy within the section. OSI comments as follows:

> SB570 requires the elimination of prior authorization and step therapy for drugs used to treat high blood pressure and diabetes contingent upon a medical necessity review. While medical necessity review is relevant for some classes of medications, the process of evaluating medical necessity for pharmacy drugs is essentially the same as requiring a prior authorization in practice. Therefore, requiring medical necessity review contradicts the prohibition on prior authorization. It would be prudent to address prior authorization and step therapy prohibitions in a separate section that eliminates medical necessity review references.

NMPSIA requests a more precise and detailed definition of "chemotherapy services" to ensure clarity and compliance with this bill upon its becoming law. By providing a more detailed definition of chemotherapy services, the bill ensures that insurance companies understand what exactly is included in the legislation. Without clarity, there could be confusion or inconsistencies in how claims are processed, potentially leading to delays or approvals of coverage for treatments that are not medically necessary.
HR/hj/SL2