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

SPONSOR HBIC **ORIGINAL DATE** 01/26/09 **LAST UPDATED** 03/16/09 **HB** 192/HBICS/aSCORC

SHORT TITLE Prescription Drug Prior Authorization Process **SB**

ANALYST Wilson

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY09	**FY10**		
NFI	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to HB 232, HB 233, HB 243, SB 40, SB82 & SB 129

SOURCES OF INFORMATION
LFC Files

Responses Received From
Health Policy Commission (HPC)
Public Regulation Commission (PRC)
Regulation & Licensing (RLD)

SUMMARY

Synopsis of SCORC Amendment

The Senate Corporations and Transportation Committee amendment allows Health Maintenance Organizations (HMO) and insurers to determine the appropriate number of days' supply of the prior authorization request.

Synopsis of Original Bill

The House Business & Industry Committee substitute for House Bill 192 amends NMSA 59A Article 22 by requiring Health Maintenance Organizations (HMO) and insurers to allow participating pharmacists licensed pursuant to the Pharmacy Act to initiate a prior authorization process when seeking to fill a prescription for a medically fragile individual.

The bill requires the insurer or HMO to notify a person requesting prior authorization on behalf of a medically fragile covered individual of its determination regarding the authorization as expeditiously as the covered individual's health condition requires, but no later than 2 business days after the insurers receives all information that it reasonable requires in instances where the request indicates that the approval is necessary to protect a medically fragile individual's health.

For the purposes of this bill medically fragile means having a health status deemed to be medically fragile by agreement between a practitioner and the individual's insurer.

Prior authorization request information regarding the procedure for submission and determination of prior authorization requests shall be prominently available on the insurer's or HMO website and also available to prescribers and pharmacists upon a written request.

An insurer that limits covered drugs to those listed on a formulary shall make information about each plan's formulary prominently available on the insurer's or HMO website and also available to prescribers and pharmacists upon a written request.

The bill provides a mechanism for appeals, rights and procedures

FISCAL IMPLICATIONS

There are no fiscal implications

SIGNIFICANT ISSUES

Prior authorization is a process where a medically fragile covered individual must obtain the permission of an HMO or insurer before any reimbursement occurs for the prescription drug claim for a non-covered drug. Currently the HMO or insurer require a medically fragile patient's practitioner to initiate a prior authorization request in order for the HMO or insurer to consider the request. In many instances, the pharmacy begins this process and sends the information to the prescriber for a signature. The prescriber must then sign the form and transmit it to the insurance company. In many cases this process can take from one to two weeks, delaying patient care.

The PRC states that the intent of this bill appears to add uniformity, speed and transparency to the process of obtaining a prescription drug, and to provide a medically fragile consumer with immediate information regarding their rights, if a prior authorization request for the prescription is denied. In trying to achieve these goals, it may be possible that an undue burden is being placed on the pharmacy, particularly in conveying the appeal and grievance rights of the individual.

ADMINISTRATIVE IMPLICATIONS

The superintendent of the Insurance Department of the PRC may need to amend or repeal current and proposed rules and will need to oversee the inclusion of the provisions of this bill in all new and all renewal insurance contracts.

The Insurance Department should be able to handle the enforcement of the provisions in this bill as part of ongoing responsibilities.

RELATIONSHIP

HB192 relates to:

HB 232, Prescription Privacy Act,
HB 233, State Prescription Drug Price Information,
HB 243, Prescription Drug Re-importation,
SB 40, Prescription Drug Donations,
SB82, Permit Re-dispensation of Unused Prescriptions,

SB 129, Prescription Drug Retail Price Disclosure.

OTHER SUBSTANTIVE ISSUES

The HBIC substitute for House Bill 192 allows pharmacists to initiate prior authorizations for medically fragile individuals. The following is a discussion of a more generalized prior authorization process provided by the HPC:

> The Kaiser Commission on Medicaid and the Uninsured published a report entitled *Prior Authorization for Medicaid Prescription Drugs in Five States: Lessons for Policy Makers,* which describes a case study regarding prescription prior authorization. Medicaid prescription drug costs have grown rapidly in recent years, motivating states to use the various cost and utilization controls available to them. One strategy used by at least 30 states is prior authorization—requiring prescribers to obtain approval from the state Medicaid agency or its contractor before a particular drug can be dispensed. States directly oversee or conduct prior authorization for their fee-for-service drug expenditures, and many Medicaid managed care plans also use some form of prior authorization for their Medicaid enrollees.
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> This report used an exploratory, case study approach to elicit the views of state officials and other key stakeholders about prior authorization in five states – California, Georgia, Oklahoma, Oregon, and Washington – all with well-established procedures. These states' experiences and perspectives may be useful for states considering implementation or expansion of prior authorization in their Medicaid programs.
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> In this study, key stakeholders indicate that prior authorization processes cause some beneficiaries and providers access and bureaucratic problems. Providers report communication problems with pharmaceutical benefit management firms under contract to the state, and they also cite the complexity of the multiple formularies or preferred drug lists they must use and the prior authorization processes they must navigate.
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> There appears to be limited monitoring of the effects of prior authorization on beneficiaries and providers at the state level. Thus, although some basic information is available about issues such as waiting times for decisions, in most states virtually nothing is known about the effect of prior authorization on individual beneficiaries' access to appropriate, medically necessary medications. Most providers' experiences are also unknown, other than information such as the average amount of time practitioners must spend on the phone with pharmaceutical benefit managers.
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> Regulation and monitoring of managed care plans' formularies and prior authorization processes appears to be minimal in some of the case study states. This is a particular concern in states where a large proportion of aged and disabled beneficiaries – the most frequent users of medications – are enrolled in managed care plans.
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> In short, creating credible prior authorization processes that are streamlined and minimize the burden on beneficiaries and providers is desirable from the perspective of most of the respondents. In addition, the need for more data regarding the effects of prior authorization on those who regularly interface with the systems, namely beneficiaries and providers, is undisputed and could inform future policy decisions. However, it is important to note that prior authorization is only one of a range of prescription drug management tools that states have at their disposal, and most states use a variety of approaches.

DW/mt:mc