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

SPONSOR Candelaria **ORIGINAL DATE** 02/18/15 03/04/15 **LAST UPDATED** 03/16/15 **HB**

SHORT TITLE Health Insurance Determination Appeals **SB** 517/aSFl#1

ANALYST Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY15	FY16	FY17	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		See Fiscal Impact	See Fiscal Impact	See Fiscal Impact		General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Human Services Department (HSD)
Office of the Superintendent of Insurance (OSI)

SUMMARY

Synopsis of Senate Floor Amendment #1

Senate Floor Amendment 1 amends the bill to change the length of time under which an HMO must provide an expedited internal appeal decision from twenty-four hours to seventy-two hours.

The amendment also adds language providing conditions under which an MCO shall provide continued coverage of a drug benefit, noting the subsection applies only when the prescription drug in question has been prescribed for at least three months as of the date of the appeal request. The amendment notes also that continued drug benefit under the subsection is not permissible for drugs obtained (1) as a sample from a health care provider, (2) by means of a coupon from the prescription drug's pharmaceutical manufacturer; (3) as part of a pharmaceutical manufacturer's study; or (4) through a cash purchase at the prescription drug's full retail price.

However, **the amendment does NOT address** Office of the Superintendent of Insurance concerns with this bill as previously noted; namely, that the bill weakens existing OSI grievance procedure regulations that were amended in 2012 pursuant to a lengthy rulemaking process to conform to the requirements of the federal model grievance procedure rule which incorporated the requirements of the Patient Protection and Affordable Care Act. The grievance procedure regulations received federal approval for compliance with federal requirements. OSI strongly recommends the concerns raised in this bill relating to continued drug benefits in cases of

internal appeals be addressed under an OSI rule change or bulletin.

Synopsis of Original Bill

Senate Bill 517 adds language to the Insurance Code regarding Health Maintenance Organizations (HMO) providing definitions for "adverse determination" and "internal appeal." The bill further amends the Insurance Code regarding internal appeals and outlines specific protocol to be followed by HMOs regarding the implementation of an internal appeal system. Regarding prescription drug benefits, the bill states specifically:

- An HMO shall issue immediate electronic authorization to the enrollee's pharmacy authorizing the continued coverage of the prescription drug that is the subject of the internal appeal pending the decision of the internal appeal; and
- Without regard to whether the adverse determination is upheld on review, an HMO shall not charge an enrollee for the cost of a health care benefit, including a prescription drug benefit, that is the subject of an internal appeal received during the period the review was considered except for an applicable copayment, coinsurance or deductible under the applicable health maintenance organization contract.

Expanded Synopsis and Concerns provided by OSI:

A. The bill makes the following changes to the Health Maintenance Organization law:

1. adds, in 59A-46-2.A, a definition of "adverse determination" which differs from the definition in the OSI regulations on grievance procedures for insureds, NMAC 13.10.17, by

a. replacing the term "a participant or beneficiary" with "enrollee", thereby reducing the scope of the definition;

b. replacing, in 59A-46-2.A(2), "and including, with respect to group health plans" with "or", thereby reducing clarity;

c. replacing, in 59A-46-2.A(3)(a) and (b), "as well as a failure to cover an item or service for which beneficiaries are otherwise provided because it is determined to be", with "or a determination that a benefit that is otherwise provided is," thereby reducing clarity;

4. adds, in 59A-46-2.J, a definition of "grievance," that excludes adverse determinations and pertains only to HMOs, which is inconsistent with and confusing when read in light of OSI regulations, which provide separate definitions for adverse determination grievances and administrative grievances and pertain to both HMOs and PPOs;

5. adds, in 59A-46-2.R, a definition of "internal appeal" as a review by an HMO of an adverse determination, which is inconsistent with and confusing when read in light of OSI regulations, which set forth regulations for both internal appeals for adverse determinations (NMAC 13.10.17.17 through 13.10.17.22) and internal appeals for administrative grievances (NMAC 13.10.17.33 through 13.10.17.36);

6. adds, to 59A-46-11 (Grievance Procedures) the phrase "Internal Appeals" thereby narrowing the meaning of the Section;

7. adds, to 59A-46-11, a subsection "C" which sets forth requirements for implementation of an internal appeal system that are already required under the OSI grievance procedure regulations, with the exception of:

a. in C(3), a 24 hr expedited review period under the proposed bill language, which is shorter than the 72-hr expedited review period under OSI regulations

b. in C(4), a 5 day period for completions of a standard internal review under the proposed bill language, which is shorter than the 20- or 40- day period for completion of a

standard internal review under OSI regulations, depending on whether the request for review is made before or after the service was provided;

c. in C(6), a requirement that the HMO considers that an internal appeal has been made if an appellant, within 30 days of issuance of an adverse determination, expresses orally or in writing, any dissatisfaction of disagreement with the adverse determination to the HMO or is agent, which is more restrictive that the OSI grievance regulations, which state that every grievant who is dissatisfied with an adverse determination shall have the right to request internal review without any time limitation;

8. adds, to 59A-46-11, a subsection "D" which requires that, in case of internal appeals of adverse determination relating to a prescription drug benefit, the HMO shall issue immediate electronic authorization to the appellants' pharmacy authorizing the continued coverage of the prescription drug that is the subject of the internal appeal pending the decision of the internal appeal;

9. adds, to section 59A-46-11, a subsection "E" which requires that the HMO, without regard to whether the adverse determination is upheld on review, shall not charge an appellant for the cost of a health care benefit, including a prescription drug benefit, that is the subject of an internal appeal received during the period the review was considered except for an applicable copayment, coinsurance or deductible under the applicable health maintenance organization contract;

10. adds a new section to the HMO law requiring notification to an appellant of an adverse decision, with no deadline for notification, requiring a written explanation of the grounds, procedures and deadlines for making an expedited appeal, and notifying the appellant of his or her right to receive the criteria on which the adverse determination was made and, if based on medical necessity, an explanation of the scientific or clinical judgment for the adverse determination, which notice is not as comprehensive as that provide by OSI regulations at 13.10.17.16;

B. The bill makes the following changes to the Patient Protection Act (PPA):

1. adds, in 59A-57-3 "Definitions," the following definitions:

a. in subsection A, a definition of "adverse determination" for which the OSI has the same comments as listed in paragraph A.1 through A.3, above;

b. in subsection B, a definition of "appellant," based on the term "enrollee" rather than "participant or beneficiary," as used throughout the OSI regulations rather than "enrollee," which limits the scope of the term, as discussed in paragraph A.1, above;

c. in subsection G., a definition of "grievance," that excludes adverse determinations and pertains only to health care insurers, which is inconsistent with and confusing when read in light of OSI regulations, which provide separate definitions for adverse determination grievances and administrative grievances and pertain to both HMOs and PPOs;

d. in subsection M, a definition of "internal appeal," as a review by a health care insurer, which is inconsistent with and confusing when read in light of OSI regulations, which set forth regulations for both internal appeals for adverse determinations (NMAC 13.10.17.17 through 13.10.17.22) and internal appeals for administrative grievances (NMAC 13.10.17.33 through 13.10.17.36); and

2. adds a new subsection "A" to the PPA requiring notification to an appellant of an adverse decision, with no deadline for notification, requiring a written explanation of the grounds, procedures and deadlines for making an expedited appeal, and notifying the appellant of his or her right to receive the criteria on which the adverse determination was made and, if based on medical necessity, an explanation of the scientific or clinical judgment for the adverse

determination, which notice is not as comprehensive as that provide by OSI regulations at 13.10.17.16; and

3. adds a new subsection "B" to the PPA which sets forth requirements for implementation of an internal appeal system that are already required under the OSI grievance procedure regulations, with the exception of:

a. in B(3), a 24 hr expedited review period under the proposed bill language, which is shorter than the 72-hr expedited review period under OSI regulations

b. in B(4), a 5 day period for completions of a standard internal review under the proposed bill language, which is shorter than the 20- or 40- day period for completion of a standard internal review under OSI regulations, depending on whether the request for review is made before or after the service was provided;

c. in B(6), a requirement that the HMO considers that an internal appeal has been made if an appellant, within 30 days of issuance of an adverse determination, expresses orally or in writing, any dissatisfaction of disagreement with the adverse determination to the HMO or is agent, which is more restrictive that the OSI grievance regulations, which state that every grievant who is dissatisfied with an adverse determination shall have the right to request internal review without any time limitation;

4. adds a new subsection "C" which requires that, in case of internal appeals of adverse determination relating to a prescription drug benefit, the health care insurer shall issue immediate electronic authorization to the appellants' pharmacy authorizing the continued coverage of the prescription drug that is the subject of the internal appeal pending the decision of the internal appeal; and

5. adds a new subsection "D" which requires that the health care insurer, without regard to whether the adverse determination is upheld on review, shall not charge an appellant for the cost of a health care benefit, including a prescription drug benefit, that is the subject of an internal appeal received during the period the review was considered except for an applicable copayment, coinsurance or deductible under the applicable health maintenance organization contract.

FISCAL IMPLICATIONS

OSI notes adoption of the proposed statutory changes would necessitate a rulemaking which would result in some administrative costs, some portion of which would be unnecessary, as discussed under "Significant Issues" below.

SIGNIFICANT ISSUES

OSI has serious concerns with this bill; in short, OSI argues the bill weakens existing OSI grievance procedure regulations that were amended in 2012 pursuant to a lengthy rulemaking process to conform to the requirements of the federal model grievance procedure rule which incorporated the requirements of the Patient Protection and Affordable Care Act. The grievance procedure regulations received federal approval for compliance with federal requirements.

Certain provisions in the bill pertaining to prescription drug benefits are new material which could be the subject of future rulemaking, even though they were not contained in the original federal model rule. However, to codify such requirements in the Insurance Code rather than in OSI regulations is a less than optimal mechanism for providing essentially regulatory protection. The obligatory rulemaking process that would arise from bill passage would incur unnecessary agency costs that could be avoided by a more limited rulemaking process focusing only on new

changes to the existing comprehensive regulatory scheme for health care grievances.

To the extent the bill proposes changes in or new definitions that are inconsistent with the definitions of terms already defined under the OSI regulations pertaining to internal reviews of adverse and administrative determinations and proposes an "Internal Review" process for adverse determinations, it requires OSI to conform its regulations to the statute through a rulemaking process. Such a rulemaking would likely be difficult and costly, because some of the bill provisions would disrupt the current internal consistency of terms and detract from policy choices that underlie some current terminology.

The bill essentially reproduces the portions of the OSI grievance procedure regulations pertaining to internal review requirements in statutory form, in certain instances either reducing the clarity or altering policy-driven terms or requirements that had received federal approval for compliance with the ACA. This effect is not desirable because the federal health care law and regulatory and sub-regulatory requirements are continuing to develop, and consistency with the federal models provides the best means of regulatory reliability for the public.

Future federal mandates may require alterations in the New Mexico requirements, and to the extent the requirements are contained in regulations rather than statutes, New Mexico can more quickly react to conform through a rulemaking rather than a process of statutory amendment.
Certain provisions in the bill pertaining to prescription drug benefits are new material which could be the subject of future rulemaking, even though they were not contained in the original federal model rule.

However, to codify such requirements in the Insurance Code rather than in OSI regulations is a less than optimal mechanism for providing essentially regulatory protection. The obligatory rulemaking process that would arise from bill passage would incur unnecessary agency costs that could be avoided by a more limited rulemaking process focusing only on new changes to the existing comprehensive regulatory scheme for health care grievances.HSD notes Section 2 adds new wording to the HMO Law affecting all insurance plans. The Medicaid program has a grievance process in place and would have to make additions as needed pursuant to SB 517.

OTHER SUBSTANTIVE ISSUES

HSD notes paragraphs D and E of the new section of the Patient Protection Act violates Art. 2, sec.19 of the New Mexico Constitution, in that it impairs obligations under the current Centennial Care contracts between HSD and each of the four (4) managed care organizations (MCOs) that participate in the State's Medicaid managed care program. Under the existing contracts the MCOs are, in accordance with 42 CFR §§ 431.230 and 438.420, as well as state regulations, permitted to recover the cost of services furnished to a beneficiary during the pendency of an appeal if the final resolution of the appeal is adverse to the beneficiary. Under the terms of the bill, the MCOs would not be permitted to recoup the costs of those services, even upon a final determination that the individual was not eligible to receive the services. Thus the costs of those services redound to the MCO, to its detriment, in violation of its contract and, therefore, Art. 2, sec. 19 of the Constitution.

ALTERNATIVES

Certain new material contained in the bill's provisions, such as those regarding prescription drug

benefits, could be addressed by future rulemaking, even though they were not contained in the original federal model rule. As stated elsewhere, to codify such requirements in the Insurance Code rather than in OSI regulations is a less than optimal mechanism for providing essentially regulatory protection.

CEB/je/aml/bb/je