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

SPONSOR Candelaria **ORIGINAL DATE** 2/8/16 **LAST UPDATED** **HB**

SHORT TITLE Drug and IV Medical Necessity Appeal **SB** 278

ANALYST Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Significant but indeterminate	Significant but indeterminate	Significant but indeterminate	Recurring	Insurance Operations Fund, General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Attorney General's Office (AGO)
Office of the Superintendent of Insurance (OSI)

SUMMARY

Synopsis of Bill

Senate Bill 278 adds the term and definition of "adverse determination of medical necessity" to the list of terms defined in the Health Maintenance Organization Law, Section 59A-46-2 NMSA 1978. An adverse determination of medical necessity would be caused by a carrier rescinding coverage or denying, reducing, terminating, or failing to make payment for a benefit.

The bill also requires carriers to provide at least 30 days notice to an enrollee before implementing an adverse determination of medical necessity relating to coverage for a prescription drug if the enrollee has been prescribed the drug for at least 30 days. The bill allows for an appeals process to be requested immediately upon receipt of the carrier's notice. Through the Office of the Superintendant of Insurance (OSI), a review and hearing shall be conducted within 20 days of the enrollee's request and without a requirement the enrollee exhaust an internal reviews process before the OSI hearing and review.

The bill also requires OSI to issue an order, within five days after the hearing, reversing or upholding the adverse determination of medical necessity. OSI is required to promulgate rules upon enactment of the new section of law.

FISCAL IMPLICATIONS

This bill could have a significant general fund impact because most of this agency's funding reverts to the general fund.

The estimated operating budget impact includes $5,000 in FY17 for OSI related to promulgating the necessary rules and creating any necessary forms.

OSI stated that the bill would have a significant but indeterminate fiscal impact upon the OSI operating budget. It requires significant new and undefined grievance, hearing, and rulemaking procedures and would impose new requirements on limited staff and resources. The bill requires completion of hearings as well as rulings including findings of fact and conclusions of law within very restrictive time constraints, compliance with which would necessarily divert staff and resources away from existing duties and responsibilities already imposed under the insurance code.

This impact cannot be estimated here because no data exist on this new procedure. It must be noted, however, that staffing and resources to accommodate new complex rulemaking and hearings are not provided for in the present budget requests for FY2017. The OSI does not have the ability or current funding to implement the new rules and regulations. OSI is not currently budgeted or have FTE positions allocated for the significant staff or hearing officers or medical expertise that will be required by this bill.

SIGNIFICANT ISSUES

OSI provided the following:

> The Bill establishes a new procedure to challenge coverage determinations for prescription drugs which have been prescribed for at least 90 days, although the definition of "adverse determination of medical necessity" in the first section is not so restricted, which may cause confusion with regard to the scope and application of the changes in the Bill. The new hearing procedures apply to prospective termination of drug prescriptions, and require a notice and the ability to challenge the proposed termination prior to the event.
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> Proposed procedures may be confusing or contradictory. For instance, Paragraph A(3) on the content of the notice both requires detail about external appeals for the determination as well as providing simultaneously for an internal appeal of the same determination. An "internal" appeal is one which occurs within the administration of the insurance company, and an "external" review of course is one outside the company to the OSI staff first, and then to District Court.
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> Because the bill mandates the Superintendent to promulgate rules implementing the grievance procedure before October of this year, clarification of the conflicting procedures may not be possible and could result in extensive and costly litigation.

OSI has an extensive health insurance grievance procedure applying to coverage issues related to prescriptions along with all covered medical benefits. The Managed Health Care Bureau has the statutory authority to ensure that the act is followed and adhered to according to the law. This grievance procedure has recently been updated through a rulemaking process, and became effective on 1 January 2016. This includes disputes relating to prescription drugs and intravenous infusions.

Also it is important to observe that these provisions already allow for the continuation of care during urgent or emergency situations. See e.g. §13.10.17.10 (A) (10) NMAC. Existing grievance procedures also allow for challenge to denial of service on grounds of medical necessity with consideration of medical exigencies of the situation. See §13.17.10.15 NMAC. Additionally the present rules allow for expedited review where required by the medical exigencies of the case. See §§13.17.10.18 and 13.10.17.26 NMAC.

It is important to note the OSI grievance rules were revised pursuant to requirements contained in the Affordable Care Act (ACA). The ACA made the requirement for all grievance procedures to mirror what the federal procedures are. This was done in order to establish rules and procedures that would be consistent from state to state in hearing disputes over medical care. Thus to the extent the Bill conflicts with, invalidates or supersedes the altered Rules, the provisions may in fact be preempted by Federal law and the US Constitution. The proposed grievance procedure in SB278 may not meet the requirements under the Affordable Care Act.

OTHER SUBSTANTIVE ISSUES

AGO stated that the bill calls for a "recommendation regarding a finding of medical necessity from a health care provider who: 1) has not previously reviewed the matter under review; and 2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure or treatment for which the prescription drug under review in the appeal was prescribed." It is unclear who will be responsible for payment to this health care provider.

There may also be some confusion with regard to timelines. While it appears there is a specific timeline for both the insurance carrier and the Office of Superintendent of Insurance, the only guidance for the enrollee is language allowing a request "immediately upon receipt of…an adverse determination." It is unclear when an enrollee would lose his or her right to make such a request.

EC/al/jle