SENATE BILL 188

54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

INTRODUCED BY

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AN ACT

RELATING TO HEALTH INSURANCE; ENACTING THE PRIOR AUTHORIZATION ACT; REQUIRING THE OFFICE OF SUPERINTENDENT OF INSURANCE TO STANDARDIZE AND STREAMLINE THE PRIOR AUTHORIZATION PROCESS FOR NON-EMERGENCY MEDICAL CARE OR RELATED BENEFITS; IMPOSING REQUIREMENTS ON HEALTH INSURERS AND THEIR PHARMACY BENEFITS MANAGERS WITH RESPECT TO PRIOR AUTHORIZATION; REQUIRING THE OFFICE OF SUPERINTENDENT OF INSURANCE AND HEALTH INSURERS TO REPORT DATA ON PRIOR AUTHORIZATION; PROHIBITING CONTRACTUAL ARRANGEMENTS THAT VIOLATE THE PRIOR AUTHORIZATION ACT; ENACTING A NEW SECTION OF THE HEALTH CARE PURCHASING ACT AND AMENDING AND ENACTING SECTIONS OF THE PUBLIC ASSISTANCE ACT TO PROVIDE FOR APPLICABILITY; PROHIBITING CERTAIN ACTIONS AS UNFAIR TRADE PRACTICES PURSUANT TO CHAPTER 59A, ARTICLE 16 NMSA 1978; MAKING CONFORMING AMENDMENTS.

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

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PRIOR AUTHORIZATION ACT.--Benefits administrators of group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act are subject to and shall comply with the Prior Authorization Act."

SECTION 2. Section 27-2-12.18 NMSA 1978 (being Laws 2013, Chapter 170, Section 1) is amended to read:

"27-2-12.18. MEDICAL ASSISTANCE--PRESCRIPTION DRUGS--PRIOR AUTHORIZATION REQUEST FORM--PRIOR AUTHORIZATION PROTOCOLS.--

A. Beginning January 1, 2014, the department shall require its medicaid contractors to accept the uniform prior authorization form developed pursuant to Sections [~~2 and 3 of this 2013 act~~] 59A-2-9.8 and 61-11-6.2 NMSA 1978. The department shall require its medicaid contractors to accept the uniform prior authorization form as sufficient to request prior authorization for prescription drug benefits on behalf of recipients.

B. The department shall require its medicaid contractors to: [~~respond within three business days upon receipt of a uniform prior authorization form. The department shall require each of its medicaid contractors to deem a prior~~

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~~authorization as having been granted if the contractor has failed to respond to the prior authorization request within three business days.~~]

(1) auto-adjudicate all electronically transmitted prescription drug prior authorization requests. Prior authorization shall be deemed granted for determinations not made within twenty-four hours;

(2) adjudicate prescription drug prior authorization requests that are not electronically transmitted within twenty-four hours following receipt. Prior authorization shall be deemed granted for determinations not made within twenty-four hours; and

(3) maintain a call center that is open from 8:00 a.m. to 6:00 p.m. mountain standard or daylight savings time, seven days a week for health care providers with a minimum:

(a) service level of eighty percent of calls answered by a live agent within twenty seconds; and

(b) first call resolution rate of seventy-five percent.

C. As used in this section:

(1) "adjudicate" means to approve or deny a request for prior authorization; and

(2) "auto-adjudicate" means to use technology and automation to make a real-time determination to approve or

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deny a request for prior authorization."

SECTION 3. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] MEDICAL ASSISTANCE--MANAGED CARE ORGANIZATION CONTRACTS--APPLICABILITY OF PRIOR AUTHORIZATION ACT.--The secretary shall ensure that contracts with managed care organizations to provide medical assistance to medicaid recipients are subject to and comply with the Prior Authorization Act."

SECTION 4. [NEW MATERIAL] SHORT TITLE.--Sections 4 through 12 of this act may be cited as the "Prior Authorization Act".

SECTION 5. [NEW MATERIAL] DEFINITIONS.--As used in the Prior Authorization Act:

A. "adjudicate" means to approve or deny a request for prior authorization;

B. "auto-adjudicate" means to use technology and automation to make a real-time determination to approve or deny a request for prior authorization;

C. "chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and that, based on reasonable medical probability, will continue for an entire or the remaining policy year;

D. "covered person" means an individual who is

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insured under a health benefits plan;

E. "emergency care" means a health care procedure, treatment or service delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

F. "health benefits plan" means a policy, contract, certificate or agreement, entered into, offered or issued by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of medical care or related benefits;

G. "health care professional" means an individual who is licensed or otherwise authorized by the state to provide health care services;

H. "health care provider" means a health care professional, corporation, organization, facility or institution licensed or otherwise authorized by the state to provide health care services;

I. "health insurer" means a health maintenance organization, nonprofit health care plan, provider service network, medicaid managed care organization or third-party payer or its agent;

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J. "medical care or related benefits" means medical, behavioral, hospital, surgical, physical rehabilitation and home health services, and includes drugs, durable medical equipment, prosthetics, orthotics and supplies;

K. "medical necessity" means the appropriateness of medical care or related benefits according to:

(1) applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) applicable clinical protocols or practice guidelines developed by the health insurer consistent with federal, national and professional practice guidelines, which shall apply to the diagnosis, direct care and treatment of a physical or behavioral health condition, illness, injury or disease;

L. "medical peer review" means review by a health care professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review for prior authorization;

M. "office" means the office of superintendent of insurance;

N. "pharmacy benefits manager" means an agent responsible for handling prescription drug benefits for a

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health insurer; and

O. "prior authorization" means advance approval that is required by a health insurer as a condition precedent to payment for medical care or related benefits rendered to a covered person, including prospective or utilization review conducted prior to the provision of covered medical care or related benefits.

SECTION 6. [NEW MATERIAL] EMERGENCY CARE.--Emergency care provided to a covered person, regardless of where the emergency care is provided, shall not be subject to prior authorization requirements.

SECTION 7. [NEW MATERIAL] DUTIES OF OFFICE--PRESCRIBING PENALTIES.--

A. To reduce the administrative burden on health care providers and reduce unnecessary delays in authorizing payment for medical care or related benefits to covered persons, the office shall standardize and streamline the prior authorization process across all health insurers.

B. On or before September 1, 2019, the office shall, in collaboration with:

(1) health insurers and health care providers, promulgate a uniform prior authorization form for medical care or related benefits other than prescription drugs to be used by every health insurer and health care provider after January 1, 2020;

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(2) the board of pharmacy, promulgate a list of medications for which no prior authorization shall be required by a health insurer;

(3) health insurers, health care providers and the board of pharmacy, promulgate criteria to exempt certain health care providers from prior authorization requirements with respect to certain medical care or related benefits, including prescription drugs, based on:

(a) low overall rates of denial of requests from health care professionals in the same practice specialty as classified in the most recent physician or surgeon specialty codes published by the international organization for standardization;

(b) low rates of denial of prior authorization for certain diagnoses and associated principal procedure codes; and

(c) low rates of denial of prior authorization for individual health care providers; and

(4) health insurers and health care providers, adopt by rule specific federal, national or professional clinical practice guidelines for the two hundred most frequently occurring diagnoses and associated principal procedure codes for family practice, pediatric and internal medicine, based on data for New Mexico from health insurers for the previous two policy years, for which no prior authorization

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shall be required. The office shall make the guidelines available to the public on the office's website.

C. Beginning on September 1, 2021, and every two years thereafter, the office shall conduct a review of, and update as necessary, the list, criteria and specific clinical practice guidelines required pursuant to Paragraphs (2) through (4) of Subsection B of this section.

D. The office shall:

(1) create, maintain and no less than annually update a list of health care professionals, nominated by state health care professional licensing boards or professional societies or associations, that are willing to provide expedited independent review of denials of prior authorization; and

(2) make the list created pursuant to Paragraph (1) of this subsection available to health care providers and health insurers on the office's website.

E. The office shall collect data regarding prior authorization approvals, denials and outcomes of requests for expedited independent review from each health insurer in a form and frequency, no less than twice annually, as determined by the office. The data shall be aggregated so that no individual patient can be identified.

F. The office shall maintain a log of complaints against health insurers for failure to comply with the Prior

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Authorization Act. The office may levy a fine of not more than one thousand dollars ($1,000) per violation on a health insurer that fails to comply with the provisions of that act.

G. By September 1, 2019, and each September 1 thereafter, the office shall provide an annual written report to the governor and the legislature to include, at a minimum:

(1) prior authorization data for each health insurer individually and for health insurers collectively;

(2) the number and nature of complaints against individual health insurers for failure to follow the Prior Authorization Act; and

(3) actions taken by the office, including the imposition of fines, against individual health insurers to enforce compliance with the Prior Authorization Act.

H. The annual written report shall be posted on the office's website.

SECTION 8. [NEW MATERIAL] PRIOR AUTHORIZATION REQUIREMENTS.--

A. A health insurer that requires prior authorization shall:

(1) use the uniform prior authorization forms developed by the office for medical care or related benefits pursuant to Section 7 of this 2019 act and for prescription drugs pursuant to Section 59A-2-9.8 NMSA 1978;

(2) establish and maintain a system for:

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(a) the secure electronic transmission of prior authorization requests for medical care or related benefits; and

(b) auto-adjudication;

(3) provide an electronic receipt to the health care provider and assign a tracking number to the health care provider's use in tracking the status of the prior authorization request, regardless of whether or not the request is tracked electronically, through a call center or by facsimile;

(4) auto-adjudicate all electronically transmitted prior authorization requests. Prior authorization shall be deemed granted for determinations not made within twenty-four hours; and

(5) adjudicate requests for medical care or related benefits that are not electronically transmitted within twenty-four hours following receipt. Prior authorization shall be deemed granted for determinations not made within twenty-four hours.

B. A health insurer shall maintain a call center that is open from 8:00 a.m. to 6:00 p.m. mountain standard time or mountain daylight time, seven days a week for health care providers with a minimum:

(1) service level of eighty percent of calls answered by a live agent within twenty seconds; and

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(2) first call resolution rate of seventy-five percent.

C. A health insurer shall not:

(1) deny payment for covered services to address conditions discovered in the course of an approved surgical or other invasive procedure if those services are rendered at the time of the approved surgical or invasive procedure; or

(2) require a health care professional to obtain more than one prior authorization per policy period for medical care or related benefits that meet the health insurer's criteria for approval for a covered person who has a permanent or chronic condition; provided that the covered person has designated such health care professional to provide such medical care or related benefits for the duration of the policy period.

D. A health insurer's denial of a request for prior authorization shall be made only by medical peer review.

E. A health insurer shall not include any provision in its health care provider agreements to circumvent, waive or avoid compliance with any provision of the Prior Authorization Act or other applicable New Mexico law and such provision shall be void. A health insurer's inclusion of a provision in a health care provider agreement that conflicts with any provision of the Prior Authorization Act constitutes an unfair

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and deceptive practice pursuant to Chapter 59A, Article 16 NMSA 1978.

SECTION 9. [NEW MATERIAL] PHARMACY BENEFITS MANAGERS.--

A. A pharmacy benefits manager shall:

(1) use the office's uniform prior authorization form;

(2) establish and maintain a system for the secure electronic transmission of prescription benefit prior authorization requests using the most recent version of the SCRIPT standard developed by the national council for prescription drug programs for electronic prescribing transactions adopted by the centers for medicare and medicaid services of the United States department of health and human services. For purposes of this subsection, a facsimile or a proprietary payer portal for prescription drug requests does not meet the requirements for secured electronic transmission;

(3) auto-adjudicate all electronically transmitted prescription drug prior authorization requests. Prior authorization shall be deemed granted for determinations not made within twenty-four hours; and

(4) adjudicate prescription drug prior authorization requests that are not electronically transmitted within twenty-four hours following receipt. Prior authorization shall be deemed granted for determinations not made within twenty-four hours.

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B. A pharmacy benefits manager shall maintain a call center that is open from 8:00 a.m. to 6:00 p.m. mountain standard time or mountain daylight time, seven days a week for health care providers with a minimum:

(1) service level of eighty percent of calls answered by a live agent within twenty seconds; and

(2) first call resolution rate of seventy-five percent.

C. The denial of a request for approval of a prescription drug shall be made by a health care professional with prescriptive authority or a pharmacist licensed in New Mexico. The notice of denial shall be given to the prescribing health care professional requesting approval and shall include a list of prescription drugs that are approved as a substitute for the prescribed drug with the corresponding dollar amount of the covered person's cost sharing for each substitute.

D. A pharmacy benefits manager shall not:

(1) make a substitute for a prescribed drug or alter the dosage of a prescribed drug without the approval of the health care professional who prescribed the drug; or

(2) contact a covered person to request, suggest or recommend a substitution for the prescribed drug or a change in the dosage of the prescribed drug.

E. A pharmacy benefits manager may provide written information to a covered person comparing the dollar amount of

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the covered person's cost sharing for a prescribed drug to that for a similar or comparable prescription drug.

F. A pharmacy benefits manager shall not request, suggest or recommend a substitution for a prescribed drug, or make a substitution for a prescribed drug if there is no clinical reason to override the prescribing health care professional's judgment or if the dollar amount of the covered person's cost sharing for the substitute is greater than for the prescribed drug.

G. A pharmacy benefits manager shall not require a covered person to purchase a prescribed drug from a specific pharmacy or through mail order.

H. A pharmacy benefits manager is prohibited from ordering a fill or refill of a prescribed drug for a covered person.

SECTION 10. [NEW MATERIAL] EXPEDITED INDEPENDENT REVIEW.--

A. A covered person has a right to an expedited independent review of an adverse prior authorization determination following medical peer review.

B. A covered person's health care professional may request an expedited independent review following medical peer review when, in the health care professional's opinion based on reasonable medical probability, delay in treatment could:

(1) seriously jeopardize the covered person's

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life or overall health;

(2) affect the covered person's ability to regain maximum function; or

(3) subject the covered person to severe and intolerable pain.

C. The request for expedited independent review shall contain the following:

(1) the tracking number assigned by the health insurer to the prior authorization request;

(2) a certification by the covered person's health care professional that, based on reasonable medical probability, delay in receipt of the requested treatment could subject the covered person to one or more of the outcomes specified in Subsection B of this section;

(3) a brief statement of the clinical basis for the requested treatment;

(4) the reason given by the health insurer for denying the request; and

(5) the name of a health care professional chosen from the list created and maintained by the office who has been contacted by the covered person's health care professional and who has agreed to provide expedited independent review of the denial of prior authorization.

D. The request for expedited independent review shall be electronically transmitted to the office, the health

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insurer and the health care professional who has agreed to provide expedited independent review.

E. The covered person's health care professional shall electronically transmit the following supporting documentation to the health care professional who has agreed to provide expedited independent review:

(1) copies of medical or hospital records and information that were provided to the health insurer by the covered person's health care professional pertaining to the request for prior authorization; and

(2) copies of documents received from the health insurer pertaining to the denial of the request for prior authorization.

F. The supporting documentation transmitted to the health care professional who has agreed to provide expedited independent review, shall be encrypted and otherwise comply with state and federal health care privacy laws to protect the covered person's privacy at all times.

G. No later than seventy-two hours after the referral, the independent reviewer shall issue and transmit a written decision to the requesting health care provider and the health insurer affirming or overturning the denial of prior authorization, and providing the basis for the decision.

H. The decision of the independent reviewer shall be binding on the covered person and on the health insurer.

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I. The independent reviewer shall not receive any compensation, perquisite or allowance. Serving as an independent reviewer pursuant to this section shall not create a therapeutic relationship between the independent reviewer and the covered person.

SECTION 11. [NEW MATERIAL] PRIOR AUTHORIZATION--TRANSPARENCY--NOTICE OF CHANGES--REPORTING.--

A. A health insurer shall make its current prior authorization requirements and restrictions, including clinical criteria, readily accessible on its website to covered persons, health care providers and the public. Notice of changes to requirements, restrictions or clinical criteria shall be given no less than sixty days prior to implementation.

B. If a health insurer intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, it shall provide covered persons who are currently approved for the affected medical care or related benefits and all contracted health care providers that provide the affected medical care or related benefits with written notice of such changes. Notice of changes to requirements, restrictions or clinical criteria shall be given no less than sixty days prior to implementation. Written notice may be made by electronic mail.

C. A health insurer's or pharmacy benefits manager's response to a health care professional's request for

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prior authorization shall state whether the request is approved, denied or incomplete. If the prior authorization is denied, the health insurer or pharmacy benefits manager shall state the specific reason for the denial and make the medical peer reviewer who denied the request available to confer with the requesting health care professional at the time of denial, and that conference may result in a change in the medical peer reviewer's determination. If the prior authorization request is incomplete, the health insurer or pharmacy benefits manager shall indicate the specific additional information that is required to complete the request.

D. A health insurer or pharmacy benefits manager shall report aggregated data regarding prior authorization approvals, denials and outcomes of expedited independent review and appeals to the office in a format and frequency, no less than twice annually, as determined by the office. The data shall include, at a minimum:

(1) the number of denials for lack of medical necessity or incomplete information;

(2) the number of approvals and denials for prescribed opioids;

(3) the number of approvals and denials for medical care or related benefits requested as an alternative to prescribed opioids; and

(4) for appeals required pursuant to the New

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Mexico Insurance Code, the:

(a) specialty of the health care professional;

(b) medical care or related benefits at issue;

(c) clinical basis for requesting the medical care or related benefits at issue;

(d) reason for the denial; and

(e) number of denials overturned on expedited independent review.

E. A health insurer shall provide a monthly report to every contracted health care provider in the state that shows to date for the current policy year:

(1) the number of requests for prior authorization submitted by the health care provider;

(2) a description of the medical care or other benefits that have been denied and the reason for the denial; and

(3) a comparison between the rates of approvals and denials of prior authorizations for the health care provider and the health care provider's peers for specific diagnoses and associated principal procedures and for requested medical care or related benefits.

SECTION 12. [NEW MATERIAL] PRIOR AUTHORIZATION DEEMED APPROVAL OF PAYMENT.--Prior authorization shall be deemed a

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guarantee of payment. Except in the case of material misrepresentation or fraud, a health insurer shall not deny payment for covered medical care or related benefits provided to a covered person by a health care provider that has relied upon the following from the health insurer's agents or employees:

A. verbal or written prior authorization; or

B. verbal or written advice that no prior authorization is required.

SECTION 13. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"[NEW MATERIAL] SUBSTITUTION OF PRESCRIBED DRUG TO MAXIMIZE REBATE PROHIBITED.--Requesting, suggesting or recommending a substitution for a prescribed drug to obtain, or making a substitution for a prescribed drug, which results in a rebate to a health insurer or pharmacy benefits manager constitutes an unfair and deceptive practice if:

A. there is no clinical reason to override the prescribing health care professional's judgment; or

B. the dollar amount of the covered person's cost sharing for the substitute is greater than for the prescribed drug."

SECTION 14. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PATTERN OR PRACTICE OF VIOLATING THE PRIOR

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AUTHORIZATION ACT--CONTRACTING TO AVOID COMPLIANCE WITH THE PRIOR AUTHORIZATION ACT.--

A. A health insurer shall not engage in a pattern or practice of violating the Prior Authorization Act.

B. A health insurer shall not include any provision in its health care provider agreements that conflicts with the provisions of the Prior Authorization Act. A health insurer's inclusion of a provision in a health care provider agreement that conflicts with the provisions of the Prior Authorization Act constitutes an unfair and deceptive practice.

C. As used in this section, "health insurer" means a health maintenance organization, nonprofit health care plan, provider service network, medicaid managed care organization or third-party payer or its agent."

SECTION 15. APPLICABILITY.--The provisions of Sections 4 through 12 of this act apply to an individual or group policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of medical care or related benefits that is entered into, offered or issued by a health insurer on or after July 1, 2019, pursuant to any of the following:

A. Chapter 59A, Article 22 NMSA 1978;

B. Chapter 59A, Article 23 NMSA 1978;

C. the Health Maintenance Organization Law;

D. the Nonprofit Health Care Plan Law; or

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E. the Health Care Purchasing Act.