



IN THE GENERAL ASSEMBLY STATE OF \_\_\_\_\_

**Ensuring Transparency in Prior Authorization Act**

1 Be it enacted by the People of the State of \_\_\_\_\_, represented in the General Assembly:

2 **Section 1. Title.** This act shall be known as and may be cited as the Ensuring Transparency in Prior  
3 Authorization Act.”

4 **Section 2. Purpose.** The Legislature hereby finds and declares that:

- 5 a) The patient-physician relationship is paramount and should not be subject to third-party intrusion;
- 6 b) Prior authorization programs place cost savings ahead of optimal patient care; and
- 7 c) Prior authorization programs shall not be permitted to hinder patient care or intrude on the  
8 practice of medicine.

9 **Section 3. Definitions.**

- 10 a) **“Adverse determination”** means a decision by a utilization review entity that the health care  
11 services furnished or proposed to be furnished to an enrollee are not medically necessary or are  
12 experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated.  
13 A decision to deny, reduce, or terminate services that are not covered for reasons other than their  
14 medical necessity, or experimental or investigational nature is not an “adverse determination” for  
15 purposes of this Act.
- 16 b) **“Authorization”** means a determination by a utilization review entity that a health care service  
17 has been reviewed and, based on the information provided, satisfies the utilization review entity’s  
18 requirements for medical necessity and appropriateness and that payment will be made for that  
19 health care service.
- 20 c) **“Clinical criteria”** means the written policies, written screening procedures, drug formularies or  
21 lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice

1 guidelines, medical protocols, and any other criteria or rationale used by the utilization review  
2 entity to determine the necessity and appropriateness of health services.

- 3 d) **“Emergency health care services”** means those health care services that are provided in an  
4 emergency facility after the sudden onset of a medical condition that manifests itself by  
5 symptoms of sufficient severity, including severe pain, that the absence of immediate medical  
6 attention could reasonably be expected by a prudent layperson, who possesses an average  
7 knowledge of health and medicine, to result in: (i) placing the patient's health in serious jeopardy;  
8 (ii) serious impairment to bodily function; or (iii) serious dysfunction of any bodily organ or part.
- 9 e) **“Health care service”** means health care procedures, treatments or services: (i) provided by a  
10 facility licensed in (indicate the name of the state); or (ii) provided by a doctor of medicine, a  
11 doctor of osteopathy, or within the scope of practice for which a health care professional is  
12 licensed in (indicate the name of the state). The term “health care service” also includes the  
13 provision of pharmaceutical products or services or durable medical equipment.
- 14 f) **“Medically necessary health care services”** Medically necessary health care services” means  
15 health care services that a prudent physician would provide to a patient for the purpose of  
16 preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:  
17 (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate  
18 in terms of type, frequency, extent, site and duration; and (iii) not primarily for the economic  
19 benefit of the health plans and purchasers or for the convenience of the patient, treating physician,  
20 or other health care provider.
- 21 g) **“Medications for opioid use disorder (MOUD)”** means the use of medications, commonly in  
22 combination with counseling and behavioral therapies, to provide a comprehensive approach to  
23 the treatment of opioid use disorder. FDA-approved medications used to treat opioid addiction  
24 include methadone, buprenorphine (alone or in combination with naloxone) and extended-release

1 injectable naltrexone. Types of behavioral therapies include individual therapy, group counseling,  
2 family behavior therapy, motivational incentives, and other modalities.

3 h) **“NCPDP SCRIPT Standard”** means the National Council for Prescription Drug Programs  
4 SCRIPT Standard Version 2017071, or the most recent standard adopted by the United States  
5 Department of Health and Human Services (HHS). Subsequently released versions of the NCPDP  
6 SCRIPT Standard may be used.

7 i) **“Prior authorization”** means the process by which utilization review entities determine the  
8 medical necessity and/or medical appropriateness of otherwise covered health care services prior  
9 to the rendering of such health care services. “Prior authorization” also includes any health  
10 insurers or utilization review entity’s requirement that an enrollee or health care provider notify  
11 the health insurer or utilization review entity prior to providing a health care service.

12 j) **“Enrollee”** means an individual eligible to receive health care benefits by a health insurer  
13 pursuant to a health plan or other health insurance coverage. The term “enrollee” includes an  
14 enrollee’s legally authorized representative.

15 k) **“Urgent health care service”** means a health care service with respect to which the application  
16 of the time periods for making a non-expedited prior authorization, which, in the opinion of a  
17 physician with knowledge of the enrollee’s medical condition:

18 i. could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to  
19 regain maximum function; or

20 ii. could subject the enrollee to severe pain that cannot be adequately managed without the  
21 care or treatment that is the subject of the utilization review.

22 For the purpose of this Act, urgent health care service shall include mental and behavioral health care  
23 services.

24 l) **“Utilization review entity”** means an individual or entity that performs prior authorization for  
25 one or more of the following entities:

- i. an employer with employees in *(indicate name of state)* who are covered under a health benefit plan or health insurance policy;
- ii. an insurer that writes health insurance policies;
- iii. a preferred provider organization, or health maintenance organization; and
- iv. any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a person treated by a health care professional in *\_\_\_\_\_ (indicate name of state)* under a policy, plan or contract.

**Section 4. Disclosure and review of prior authorization requirements.**

A utilization review entity shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public. This includes the written clinical criteria. Requirements shall be described in detail but also in easily understandable language.

- a) If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement is not implemented unless the utilization review entity's Web site has been updated to reflect the new or amended requirement or restriction.
- b) If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall provide contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented.
- c) Entities using prior authorization shall make statistics available regarding prior authorization approvals and denials on their Web site in a readily accessible format. They should include categories for:
  - i. physician specialty;

- 1           ii. medication or diagnostic test/procedure;
- 2           iii. indication offered;
- 3           iv. reason for denial;
- 4           v. if appealed;
- 5           vi. if approved or denied on appeal;
- 6           vii. the time between submission and the response.

7 **Section 5. Reporting data to Department of Insurance.**

8           (a) By March 1 of each year, each utilization review entity shall submit a report to the Department of  
9           Insurance using forms and, in a manner, specified by the Insurance Commissioner, that contains  
10           all of the following information for prior authorization requests for previous calendar year. For  
11           each health care service listed in (i), the information required by (ii-ix) should be individualized  
12           for each listed health care service.

- 13           i. A list of all health care services that require prior authorization;
- 14           ii. The number and percentage of prior authorization requests that were approved;
- 15           iii. The number and percentage of prior authorization requests that were denied;
- 16           iv. The number and percentage of prior authorization requests that were initially denied  
17           and approved after appeal;
- 18           v. The number and percentage of prior authorization requests for which the timeframe  
19           for review was extended, and the request was approved;
- 20           vi. The average and median time that elapsed between the submission of a non-urgent  
21           prior authorization request and a determination by a utilization review entity;
- 22           vii. The average and median time that elapsed between the submission of an urgent prior  
23           authorization request and a determination by the utilization review entity;

1           viii. The average and median time that elapsed to process an appeal submitted by a health  
2           care professional initially denied by the utilization review entity for non-urgent prior  
3           authorizations; and

4           ix. The average and median time that elapsed to process an appeal submitted by a health  
5           care professional initially denied by the utilization review entity for urgent prior  
6           authorizations.

7       (b) Each utilization review entity shall make the report identified in subsection(a) available through  
8       the utilization review entity’s website in the format prescribed by the Department of Insurance.

9       (c) By May 1 of each year, the Department of Insurance shall submit a report to the legislature that  
10      includes a summary of the reports identified in subsection (a), including all data that the  
11      Department of Insurance receives from each utilization review entity, and recommendations for  
12      the removal of prior authorization requirements by utilization review entities on health care  
13      services that are regularly approved for prior authorization. Any health care service that is  
14      approved more than 80% of the time shall be considered regularly approved.

15      (d) The Department of Insurance shall promulgate rules and regulations necessary to implement this  
16      section within 6 months of this law taking effect.

17      **Section 6. Personnel qualified to make adverse determinations.** A utilization review entity must

18      ensure that all adverse determinations are made by a physician. The physician must:

19      a) possess a current and valid non-restricted license to practice medicine in\_\_ (*the state in which the*  
20      *proposed services would have been provided if authorized*);

21      b) be of the same specialty as the physician who typically manages the medical condition or disease  
22      or provides the health care service involved in the request;

23      c) have experience treating patients with the medical condition or disease for which the health care  
24      service is being requested; and

1 d) make the adverse determination under the clinical direction of one of the utilization review  
2 entity's medical directors who is responsible for the provision of health care services provided to  
3 enrollees of\_\_\_\_(*state in which the proposed health care items or services would have been*  
4 *provided if authorized*). All such medical directors must be physicians licensed in\_\_\_\_(*the*  
5 *state in which the proposed health care items or services would have been provided if*  
6 *authorized*).

7 **Section 7. Consultation prior to issuing an adverse determination.** If a utilization review entity is  
8 questioning the medical necessity of a health care service, the utilization review entity must notify the  
9 enrollee's physician that medical necessity is being questioned. Prior to issuing an adverse determination,  
10 the enrollee's physician must have the opportunity to discuss the medical necessity of the health care  
11 service on the telephone with the physician who will be responsible for determining authorization of the  
12 health care service under review.

13 **Section 8. Requirements applicable to the physician who can review appeals.** A utilization entity  
14 must ensure that all appeals are reviewed by a physician. The physician must:

- 15 a. possess a current and valid non-restricted license to practice medicine in \_\_\_\_\_ (*the state in*  
16 *which the proposed services would be provided if authorized*);
- 17 b. be currently in active practice in the same or similar specialty as physician who typically manages  
18 the medical condition or disease for at least five (5) consecutive years;
- 19 c. be knowledgeable of, and having experience providing, the health care services under appeal;
- 20 d. not be employed by a utilization review entity or be under contract with the utilization review  
21 entity other than to participate in one or more of the utilization review entity's health care  
22 provider networks or to perform reviews of appeals, or otherwise have any financial interest in  
23 the outcome of the appeal;
- 24 e. not have been directly involved in making the adverse determination; and
- 25 f. consider all know clinical aspects of the health care service under review, including but not

1 limited to, a review of all pertinent medical records provided to the utilization review entity by  
2 the enrollee's health care provider, any relevant records provided to the utilization review entity  
3 by a health care facility, and any medical literature provided to the utilization review entity by the  
4 health care provider.

5 **Section 9: Transparency of adverse determinations and denials**

- 6 a. When issuing an adverse determination, the utilization review entity must provide the enrollee  
7 and requesting health care provider with the following:
- 8 i. The utilization review entity's reasons for making an adverse determination based  
9 on its prior authorization requirements;
  - 10 ii. The clinical criteria used in making the adverse determination;
  - 11 iii. The enrollee's right to appeal;
  - 12 iv. The process to file an appeal; and
  - 13 v. All information necessary to support a successful appeal of the adverse  
14 determination.
- 15 b. When issuing a denial of an appeal, the utilization review entity must provide the enrollee and  
16 requesting health care provider the following:
- 17 i. The utilization review entity's reasons for denying the appeal;
  - 18 ii. The clinical criteria used in determining the denial of the appeal;
  - 19 iii. The process for challenging the determination [at the next appeal level]; and
  - 20 iv. All information necessary to support a successful second level appeal (*this*  
21 *provision only applies if the next level is not an external review process*).
- 22 c. A notification of an adverse determination and a denial of an appeal must include the National  
23 Provider Identifier of the physician who reviewed the prior authorization request and is  
24 responsible for the determination, as well as the physician's credentials, board certifications, and  
25 areas of specialty expertise and training.

1 **Section 10. Utilization review entity’s obligations with respect to prior authorizations in non-**

2 **urgent circumstances.** If a utilization review entity requires prior authorization of a health care service,  
3 the utilization review entity must make a prior authorization or adverse determination and notify the  
4 enrollee and the enrollee’s health care provider of the prior authorization or adverse determination within  
5 48 hours of obtaining all necessary information to make the prior authorization or adverse determination.  
6 For purposes of this section, "necessary information" includes the results of any face-to-face clinical  
7 evaluation or second opinion that may be required.

8 **Section 11. Utilization review entities’ obligations with respect to prior authorizations concerning**

9 **urgent health care services.** A utilization review entity must render a prior authorization or adverse  
10 determination concerning urgent health care services. A utilization review entity must render a prior  
11 authorization or adverse determination concerning urgent care services, and notify the enrollee and the  
12 enrollee’s health care provider of that prior authorization or adverse determination not later than twenty-  
13 four (24) hours after receiving all information needed to complete the review of  
14 the requested health care services.

15 **Section 12. Utilization review entities’ obligations with respect to prior authorizations concerning**

16 **emergency health care services.**

- 17 a. A utilization review entity cannot require prior authorization for pre-hospital transportation or for  
18 the provision of emergency health care services.
- 19 b. A utilization review entity shall allow an enrollee and the enrollee’s health care provider a  
20 minimum of twenty-four (24) hours following an emergency admission or provision of  
21 emergency health care services for the enrollee or health care provider to notify the utilization  
22 review entity of the admission or provision of health care services. If the admission or health care  
23 service occurs on a holiday or weekend, a utilization review entity cannot require notification  
24 until the next business day after the admission or provision of the health care services.
- 25 c. A utilization review entity shall cover emergency health care services necessary to screen and

1 stabilize an enrollee. If a health care provider certifies in writing to a utilization review entity  
2 within seventy-two (72) hours of an enrollee's admission that the enrollee's condition required  
3 emergency health care services, that certification will create a presumption that the emergency  
4 health care services were medically necessary and such presumption may be rebutted only if the  
5 utilization review entity can establish, with clear and convincing evidence, that the emergency  
6 health care services were not medically necessary.

7 d. The medical necessity or appropriateness of emergency health care services cannot be based on  
8 whether those services were provided by participating or nonparticipating providers. Restrictions  
9 on coverage of emergency health care services provided by nonparticipating providers cannot be  
10 greater than restrictions that apply when those services are provided by participating providers.

11 e. If an enrollee receives an emergency health care service that requires immediate post evaluation  
12 or post-stabilization services, a utilization review entity shall make an authorization determination  
13 within sixty (60) minutes of receiving a request; if the authorization determination is not made  
14 within sixty (60) minutes, such services shall be deemed approved.

15 **Section 13. No prior authorization for MOUD.** A utilization review entity may not require prior  
16 authorization for provision of MOUD.

17 **Section 14. Retrospective denial.**

18 a. The utilization review entity may not revoke, limit, condition or restrict a prior authorization if  
19 care is provided within 45 business days from the date the health care provider received the prior  
20 authorization.

21 b. A utilization review entity may not deny payment for a health care service that has received  
22 approval per a prior authorization unless:

23 i. the health care provider knowingly and materially misrepresented the health care service  
24 in the prior authorization request with the specific intent to deceive and obtain an  
25 unlawful payment from utilization review entity; or

1           ii. the enrollee was no longer eligible for health care coverage on the day the care was  
2           provided.

3           c. A utilization review entity may not deny or limit coverage of a health care service which the  
4           enrollee has already received solely on the basis of lack of prior authorization if the service would  
5           otherwise have been covered had the prior authorization been obtained.

6   **Section 15. Length of prior authorization.** A prior authorization shall be valid for a minimum of one  
7   year from the date the health care provider receives the prior authorization, and the authorization period  
8   shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care  
9   provider.

10 **Section 16. Length of prior authorization for treatment for chronic or long-term conditions.** If a  
11 utilization review entity requires a prior authorization for a health care service for the treatment of a  
12 chronic or long-term condition, the prior authorization shall remain valid for the length of the treatment  
13 and the utilization review entity may not require the enrollee to obtain a prior authorization again for the  
14 health care service.

15 **Section 17. Continuity of care for enrollees.**

16           a. On receipt of information documenting a prior authorization from the enrollee or from the enrollee's  
17           health care provider, a utilization review entity shall honor a prior authorization granted to an  
18           enrollee from a previous utilization review entity for at least the initial 90 days of an enrollee's  
19           coverage under a new health plan.

20           b. During the time period described in paragraph (a) of this subsection, a utilization review entity may  
21           perform its own review to grant a prior authorization.

22           c. If there is a change in coverage of, or approval criteria for, a previously authorized health care  
23           service, the change in coverage or approval criteria does not affect an enrollee who received prior  
24           authorization before the effective date of the change for the remainder of the enrollee's plan year.

- 1 d. A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee  
2 when the enrollee changes products under the same health insurance company.

3 **Section 18. Provider exemptions from prior authorization requirements.**

- 4 a. A utilization review entity may not require a health care provider to complete a prior  
5 authorization for a health care service in order for the enrollee to whom the service is being  
6 provided to receive coverage if in the most recent 12-month period, the utilization review entity  
7 has approved or would have approved not less than 80 percent of the prior authorization requests  
8 submitted by the health care provider for that health care service, including any approval granted  
9 after an appeal.
- 10 b. A utilization review entity may evaluate whether a health care provider continues to qualify for  
11 exemptions as described in Subsection (a) not more than once every 12 months. Nothing in this  
12 Section requires a utilization review entity to evaluate an existing exemption or prevents a  
13 utilization review entity from establishing a longer exemption period.
- 14 c. A health care provider is not required to request an exemption in order to qualify for an  
15 exemption.
- 16 d. A health care provider who does not receive an exemption may request from the utilization  
17 review entity at any time, but not more than once per year per service, evidence to support the  
18 utilization review entity's decision. A health care provider may appeal a utilization review  
19 entity's decision to deny an exemption.
- 20 e. A utilization review entity may only revoke an exemption at the end of the 12-month period if the  
21 utilization review entity:
- 22 i. makes a determination that the health care provider would not have met the 80 percent  
23 approval criteria based on a retrospective review of the claims for the particular service  
24 for which the exemption applies for the previous 3 months, or for a longer period if  
25 needed to reach a minimum of 10 claims for review;

- 1           ii. provides the health care provider with the information it relied upon in making its  
2           determination to revoke the exemption; and
- 3           iii. provides the health care provider a plain language explanation of how to appeal the  
4           decision.
- 5 f. An exemption remains in effect until the 30th day after the date the utilization review entity  
6 notifies the health care provider of its determination to revoke the exemption or, if the health care  
7 provider appeals the determination, the fifth day after the revocation is upheld on appeal.
- 8 g. A determination to revoke or deny an exemption must be made by a health care provider licensed  
9 in [state] of the same or similar specialty as the health care provider being considered for an  
10 exemption and have experience in providing the service for which the potential exemption  
11 applies.
- 12 h. A utilization review entity must provide a health care provider that receives an exemption a  
13 notice that includes:
- 14           i. A statement that the health care provider qualifies for an exemption from  
15           preauthorization requirements;
- 16           ii. A list of services for which the exemption(s) apply; and
- 17           iii. A statement of the duration of the exemption.
- 18 i. A utilization review entity shall not deny or reduce payment for a health care service exempted  
19 from a prior authorization requirement under this section, including a health care service  
20 performed or supervised by another health care provider when the health care provider who  
21 ordered such service received a prior authorization exemption, unless the rendering health care  
22 provider: (1) knowingly and materially misrepresented the health care service in request for  
23 payment submitted to the utilization review entity with the specific intent to deceive an obtain an  
24 unlawful payment from utilization review entity; or (2) failed to substantially perform the health  
25 care service.

1 **Section 19. Electronic standards for prior authorization.** No later than January 1, 20XX, the payer  
2 must accept and respond to prior authorization requests under the pharmacy benefit through a secure  
3 electronic transmission using the NCPDP SCRIPT Standard ePA transactions. Facsimile, propriety payer  
4 portals, electronic forms, or any other technology not directly integrated with a physician’s electronic  
5 health record/electronic prescribing system shall not be considered secure electronic transmission.

6 **Section 20. Health care services deemed authorized if a utilization review entity fails to comply**  
7 **with the requirements of this Act.** Any failure by a utilization review entity to comply with the  
8 deadlines and other requirements specified in this Act will result in any health care services subject to  
9 review to be automatically deemed authorized by the utilization review entity.

10 **Section 21. Severability.** If any provision of this Act is held by a court to be invalid, such invalidity  
11 shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby  
12 declared severable.