SB0274S01 compared with SB0274

~~{Omitted text}~~ shows text that was in SB0274 but was omitted in SB0274S01
inserted text shows text that was not in SB0274 but was inserted into SB0274S01

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Health Insurance Preauthorization Revisions

2025 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: John D. Johnson

House Sponsor:

LONG TITLE

General Description:

This bill amends provisions related to health insurance preauthorization.

Highlighted Provisions:

This bill:

- requires health insurers to provide information related to preauthorization to the Department of Insurance, patients, and health care providers.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

AMENDS:

31A-22-650 , as enacted by Laws of Utah 2019, Chapter 439 , as enacted by Laws of Utah 2019, Chapter 439

Be it enacted by the Legislature of the state of Utah:

SB0274

Section 1. Section **31A-22-650** is amended to read:

31A-22-650. Health care preauthorization requirements.

(1) As used in this section:

(a) "Adverse preauthorization determination" means a determination by an insurer that health care does not meet the preauthorization requirement for the health care.

(b) "Authorization" means a determination by an insurer that for health care with a preauthorization requirement:

(i) the proposed drug, device, or covered service meets all requirements, restrictions, limitations, and clinical criteria for authorization established by the insurer;

(ii) the drug, device, or covered service is covered by the enrollee's insurance policy; and

(iii) the insurer will provide coverage for the drug, device, or covered service subject to the provisions of the insurance policy, including any cost sharing responsibilities of the enrollee.

(c) "Device" means a prescription device as defined in Section 58-17b-102.

(d) "Drug" means the same as that term is defined in Section 58-17b-102.

(e) "Insurer" means the same as that term is defined in Section 31A-22-634.

(f) "Preauthorization requirement" means a requirement by an insurer that an enrollee obtain authorization for a drug, device, or service covered by the insurance policy, before receiving the drug, device, or service.

(2)

(a) An insurer may not modify an existing requirement for authorization unless, at least 30 days before the day on which the modification takes effect, the insurer:

(i) posts a notice of the modification on the website described in Subsection 31A-22-613.5(6)(a); and

(ii) if requested by a network provider or the network provider's representative, provides to the network provider by mail or email a written notice of modification to a particular requirement for authorization described in the request from the network provider.

(b) Subsection (2)(a) does not apply if:

(i) complying with Subsection (2)(a) would create a danger to the enrollee's health or safety; or

(ii) the modification is for a newly covered drug or device.

(c) An insurer may not revoke an authorization for a drug, device, or covered service if:

(i) the network provider submits a request for authorization for the drug, device, or covered service to the insurer;

(ii) the insurer grants the authorization requested under Subsection (2)(c)(i);

(iii) the network provider renders the drug, device, or covered service to the enrollee in accordance with the authorization and any terms and conditions of the network provider's contract with the insurer;

(iv) on the day on which the network provider renders the drug, device, or covered service to the enrollee:

(A) the enrollee is eligible for coverage under the enrollee's insurance policy; and

(B) the enrollee's condition or circumstances related to the enrollee's care have not changed;

(v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection (2)(c)(i); and

(vi) the authorization was not based on fraudulent or materially incorrect information from the network provider.

(3)

(a) An insurer that receives a request for authorization shall treat the request as a pre-service claim as defined in 29 C.F.R. Sec. 2560.503-1 and process the request in accordance with:

(i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an individual or group health insurance policy;

(ii) Subsection 31A-4-116(2); and

(iii) Section 31A-22-629.

(b) If a network provider submits a claim to an insurer that includes an unintentional error that results in a denial of the claim, the insurer shall permit the network provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time.

(c) Except as provided in Subsection (3)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.

(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:

(i) a physician and surgeon; or

(ii) a pharmacist.

(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:

(i) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or

(ii) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination.

(f) An insurer shall specify how long an authorization is valid.

(4)

(a) An insurer that removes a drug from the insurer's formulary shall:

(i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and

(ii) have a process to review and make a decision regarding an exemption requested under Subsection (4)(a)(i).

(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.

(5)

(a) [~~Before April 1, 2021, and before April 1 of each year thereafter, ~~] Each April 1, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.

(b) Before March 1, 2026, and each March 1 thereafter, an insurer shall report to the department the following for the previous calendar year:

(i) a list of services that have preauthorization requirements;

(ii) for pre-service preauthorization requests{~~, aggregated for all services~~} that were not urgent, the percentage of individual service requests that:

(A) {~~the percentage of requests that~~ } were approved;

(B) {~~the percentage of requests that~~ } were denied;

(C) {~~the percentage of requests that~~ } were approved after appeal;

{~~(D) {the average and median time that elapsed between the submission of a request and the final determination; and}~~ }

{~~(E)~~} (D) {~~the percentage of requests for which time frame for review was extended, and the request was approved;~~ } the percentage of requests for which time frame for review was extended, and the request was approved; {~~and~~}

(E) were denied due to incomplete information from the health care provider; and

(F) were received through fax, phone, and electronic portal; and

(iii) for urgent pre-service preauthorization requests, {~~aggregated for all services~~} the percentage of individual service requests that:

(A) {~~the percentage of requests that~~ } were approved;

(B) {~~the percentage of requests that~~ } were denied; {~~and~~}

{~~(C) {the average and median time that elapsed between the submission of a request and the final determination.}~~ }

(C) were denied due to incomplete information from the health care provider; and

(D) were received through fax, phone, and electronic portal.

(c) Data provided to the department under Subsections (5)(b)(ii) and (iii) shall be aggregated for all services.

{~~(c)~~} (d) Subsection (5)(b) does not require an insurer to report information regarding prescription drugs.

{~~(d)~~} (e) The department shall compile the information described in Subsection (5)(b) and publish the information on the department's website.

(6) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.

(7) For each adverse preauthorization determination made by an insurer, the insurer shall provide to the enrollee and the enrollee's health care provider:

(a) a detailed and specific explanation that explains why the determination was made; and

(b) a notice explaining the determination may be appealed and the process for appealing the determination, including how to begin an expedited appeal process as described in Section 31A-22-629.

(8) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules to implement Subsection (5)(b).

Section 2. **Effective date.**

This bill takes effect on May 7, 2025.

2-21-25 11:40 AM