MEDICAL TREATMENT PRIOR AUTHORIZATION

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor:  Evan J. Vickers

House Sponsor:  Michael S. Kennedy

LONG TITLE

General Description:
This bill amends provisions of the Insurance Code relating to prior authorization and step therapy.

Highlighted Provisions:
This bill:

- defines terms;
- requires a health insurer to provide certain information about prior authorizations to enrollees and providers;
- specifies how prior authorizations may be used by a health insurer;
- creates restrictions on the use of prior authorizations in certain circumstances;
- beginning January 1, 2019, requires a health insurer to receive prior authorization transactions electronically and in accordance with specified standards;
- specifies that the provisions of this bill apply to a health benefit plan renewed or entered into on or after January 1, 2019; and
- requires rulemaking by the Insurance Department.

Money Appropriated in this Bill:
None

Other Special Clauses:
None

Utah Code Sections Affected:
Be it enacted by the Legislature of the state of Utah:

Section 1. Section 31A-22-647 is enacted to read:


(1) As used in this section:

(a) "Adverse determination" means a determination by a health insurer that payment for health care is denied, reduced, or terminated because the health care does not meet the requirements, restrictions, or clinical criteria for prior authorization established under Subsection (2)(a).

(b) "Authorization" means a determination by a health care insurer that payment for health care will be made because the health care meets the requirements, restrictions, or clinical criteria for prior authorization established under Subsection (2)(a).

(c) "Clinical criteria" means the written criteria used by a health insurer to make an authorization or adverse determination, including:

(i) medical practice guidelines;

(ii) medical practice protocols, including step therapy protocols; and

(iii) drug formulary requirements.

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

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

(f) "Emergency facility" means a facility designated under Section 26-8a-303 as an emergency medical service provider.

(g) "Emergency health care" means health care provided for an emergency medical condition, as defined in Section 31A-22-627.

(h) "Health care" means a professional service, a personal service, a facility, equipment, a device, supplies, or medicine:

(i) intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment; and

(ii) provided by a health care provider licensed under:

(A) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
(B) Title 58, Occupations and Professions.

(i) "Health insurer" means:

(ii) an insurer that issues a health benefit plan; and

(j) "Medically necessary" means, with respect to health care, health care that a prudent
physician would provide to a patient for the purpose of preventing, diagnosing, or treating an
illness, injury, or disease, or the symptoms of an illness, injury, or disease, in a manner that is:

(i) in accordance with generally accepted standards of medical practice;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(iii) not based primarily on:

(A) the economic consequences to the patient, a health insurer, or others paying for the
service; or

(B) convenience to the patient or the health care provider.

(k) "Participating provider" means a health care provider that has a contractual
relationship with a health insurer.

(l) "Pre-hospital transportation" means transportation by an emergency medical service
provider to an emergency facility.

(m) "Prior authorization" means a requirement to obtain an authorization, including:

(i) preadmission review;

(ii) pretreatment review;

(iii) utilization review;

(iv) case management; and

(v) a health insurer's requirement that an enrollee or the enrollee's health care provider
notify the health insurer or another person before the enrollee receives particular health care.

(n) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395(e)(3).

(o) "Step therapy protocol" means a protocol that establishes the order in which health
care must be provided to receive authorization.

(p) "Urgent health care" means health care that:

(i) if not received by an enrollee within one business day after a request for
authorization for the health care;

(A) could seriously jeopardize the life or health of the enrollee or the ability of the
enrollee to regain maximum function; or

(B) could subject the enrollee to severe pain that cannot be adequately managed without the health care; and

(ii) is not emergency health care.

(2) (a) A health insurer shall:

(i) provide the following information to the health insurer's enrollees and participating providers:

(A) a list of each drug, device, and service for which prior authorization is required;

(B) all requirements, restrictions, and clinical criteria for prior authorization; and

(C) a description of the types of information a health care provider or enrollee must submit to the health insurer to receive authorization for each drug, device, or service, including, if applicable, the results of a face-to-face clinical evaluation or a second opinion;

(ii) make the information required by Subsection (2)(a)(i) available:

(A) on a website that is accessible to the health insurer's enrollees and participating providers; and

(B) in language that is detailed and easy to understand; and

(iii) publish on a regular basis, for each request for authorization that the health insurer has received over the past five years, on the website described in Subsection (2)(a)(ii)(A), the following information, in a manner that is consistent with federal and state law:

(A) the drug, device, or service for which prior authorization was requested;

(B) if a health care provider made the request on behalf of an enrollee, the health care provider's practice specialty;

(C) a brief description of the reason for the request; and

(D) the determination made by the health insurer in response to the request.

(b) A health insurer may not modify a prior authorization requirement unless the health insurer provides the health insurer's participating providers with written notice of the modification on the website described in Subsection (2)(a)(ii)(A) at least 60 days before the day on which the modification takes effect.

(3) (a) Upon receiving a request for authorization that includes the information required by the insurer under Subsection (2)(a)(i)(C), a health insurer shall notify the person making the request, in accordance with the requirements described in Subsection (9), of the
health insurer's authorization or adverse determination:

(i) within 60 minutes from the time that the health insurer receives the request, if the request is for authorization for health care that is required immediately after the provision of emergency health care;

(ii) within one business day after the health insurer receives a request, if the request is for authorization for health care that is urgent health care; and

(iii) within two business days after the health insurer receives a request, if the request is for authorization for health care that is not described in Subsection (3)(a)(i) or (ii).

(b) In addition to the enforcement penalties and procedures described in Section 31A-2-308, if the health insurer does not notify the enrollee or health care provider in accordance with the time frames described in Subsection (3)(a) or if the health insurer violates any provision of this section as to a particular authorization, authorization is considered granted by the health insurer.

(c) (i) If a health insurer makes an adverse determination, the notification shall include the reasons for the adverse determination, including reference to specific information required by the health insurer under Subsection (2)(a)(i)(C).

(ii) The health insurer shall ensure that an adverse determination is made by an individual licensed as a physician, as defined in Section 58-67-102, who:

(A) has knowledge of and experience with managing the medical condition or disease of the enrollee for whom the authorization is requested; or

(B) consults with a physician who has knowledge of and experience with managing the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination.

(iii) The reviewing physician shall make an adverse determination under the clinical supervision of one of the health insurer's medical directors who is licensed as a physician, as defined in Section 58-67-102, in Utah and who is responsible for supervising the provision of health care services to enrollees in Utah.

(d) If a request for authorization under Subsection (3)(a) is missing information required by an insurer under Subsection (2)(a)(i)(B), the health insurer shall notify the person making the request of the missing information within the time periods established in Subsection (3)(a).
(e) (i) An authorization under Subsection (3)(a) or (b) is valid for one year, unless the authorization is amended or revoked.

(ii) An authorization under Subsection (3)(a) or (b) may not be amended or revoked for 45 days after the authorization is given under Subsection (3)(a) or considered granted under Subsection (3)(b).

(4) (a) Except as provided in Subsection (4)(b), a health insurer is not required to pay a claim for health care if the health care:

(i) is subject to prior authorization; and

(ii) was not authorized under Subsection (3)(a) or (b).

(b) Health care is not subject to a prior authorization requirement if:

(i) the health care for which the authorization is normally required is directly related to health care for which authorization has already been given; and

(ii) the health care provider did not know that the health care for which authorization is normally required was needed until the health care provider provided the health care that was authorized or did not require authorization.

(5) (a) A health insurer may not:

(i) require any form of preauthorization for emergency health care until after the enrollee's condition has been stabilized; or

(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the enrollee's emergency medical condition, as defined in Section 31A-22-627.

(b) In making a determination of whether the emergency health care received by the enrollee is medically necessary or medically appropriate, the health insurer shall ensure that the determination is made without regard to whether the provider of the emergency health care is one of the health insurer's participating providers.

(6) A health insurer shall pay a claim from a health care provider if:

(a) a health insurer has approved at least 90% of the requests for authorization from a health care provider over the previous year for:

(i) a particular CPT code for a particular medication; or

(ii) a particular ICD-10 diagnosis code;

(b) the health care provider that meets the requirement in Subsection (6)(a) has
(7) (a) A health insurer shall provide, in the health insurer's requirements for
authorization, an allowance for continuity of care for an enrollee who is undergoing an active
course of treatment when there is a formulary or treatment coverage change or a change of
health plan that might otherwise disrupt the enrollee's current course of treatment.

(b) A health insurer shall support continuity of care for medical services and
prescription medications for enrollees on appropriate, chronic, stable therapy by minimizing
repetitive prior authorization requirements.

(8) A health insurer may not apply prior authorization to pre-hospital transportation.

(9) (a) Beginning January 1, 2019, a health insurer shall accept requests for
authorization under Subsection (3):

(i) for authorization of medical services, through a secure electronic transmission that
meets the requirements for the transmission of health data established by the Accredited
Standards Committee X12; or

(ii) for a device dispensed by a pharmacy or a drug covered under a pharmacy benefit
program or prescription drug program:

(A) the most recent standard adopted by the department to address transmission of
prescription information electronically between prescribers, pharmacies, health insurers, and
other entities; or

(B) the most recent SCRIPT standard by the National Council for Prescription Drug
Program that is compatible with version 201310 of the SCRIPT standard, if that SCRIPT
standard is adopted by the United States Department of Health and Human Services.

(b) A facsimile communication, proprietary payer portal, or electronic form is not a
secure electronic transmission under Subsection (9)(a).

(c) A health insurer that receives a request for authorization from a health care provider
in accordance with Subsection (9)(a) shall immediately confirm receipt of the request to the


health care provider by the same means through which the request for authorization was received.

(10) A health insurer may not prohibit resubmission of a claim solely because the claim was originally submitted with erroneous information.

(11) (a) A health insurer shall pay a claim for health care that is subject to step therapy if:

(i) the health care is provided in accordance with the health insurer's step therapy protocol; or

(ii) (A) the health care is not provided in accordance with the health insurer's step therapy protocol; and

(B) the health care provider that provides the health care determines that the step therapy protocol is not in the enrollee's best interest.

(b) A health insurer may not, as a condition of paying a claim, require a health care provider who believes that certain health care under a step therapy protocol is not in the enrollee's best interest, to obtain a waiver, exception, override, or other form of approval by the health insurer before the health care provider provides the health care.

(c) A health insurer may not sanction or otherwise penalize a health care provider for determining that a step therapy protocol is not in an enrollee's best interest.

(12) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consultation with the Physicians Licensing Board, created in Section 58-67-201, and the Osteopathic Physician and Surgeon's Licensing Board, created in Section 58-68-201:

(a) define for the purposes of this section:

(i) "business day"; and

(ii) "practice specialty"; and

(b) adopt standards for the transmission of prescription information.

(13) This section applies to a health benefit plan renewed or entered into on or after January 1, 2019.