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S.B. 264
1st Sub. (Green)

Senator Evan J. Vickers proposes the following substitute bill:

MEDICAL TREATMENT AUTHORIZATION AMENDMENTS

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Evan J. Vickers

House Sponsor: Suzanne Harrison

LONG TITLE

General Description:

This bill enacts provisions relating to preauthorization of health care.

Highlighted Provisions:

This bill:

- defines terms;
- requires an insurer to post certain information regarding requirements for the authorization for health care;
- prohibits an insurer from denying certain requests for authorization of health care;
- requires an insurer to respond to a request for authorization for health care within a certain time period;
- creates requirements when an insurer changes certain policies in the middle of a plan year; and
- creates a reporting requirement.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

1st Sub. S.B. 264

AMENDS:

31A-2-201.2, as last amended by Laws of Utah 2018, Chapter 319

31A-4-116, as last amended by Laws of Utah 2002, Chapter 308

31A-22-613.5, as last amended by Laws of Utah 2017, Chapters 241 and 292

ENACTS:

31A-22-650, Utah Code Annotated 1953

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

Section 1. Section **31A-2-201.2** is amended to read:

31A-2-201.2. Evaluation of health insurance market.

(1) Each year the commissioner shall:

(a) conduct an evaluation of the state's health insurance market;

(b) report the findings of the evaluation to the Health and Human Services Interim Committee before December 1 of each year; and

(c) publish the findings of the evaluation on the department website.

(2) The evaluation required by this section shall:

(a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:

(i) the availability and marketing of individual and group products;

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

(b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;

(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; [~~and~~]

(d) include claims loss ratio data for each health insurance company doing business in

the state[~~.~~]; and

(e) include information, for each health insurance company doing business in the state, regarding:

(i) preauthorization determinations; and

(ii) adverse benefit determinations.

(3) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(4) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(5) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Section 2. Section **31A-4-116** is amended to read:

31A-4-116. Adverse benefit determination procedures.

(1) If an insurer has established a complaint resolution body or grievance appeal board, the body or board shall include at least one consumer representative.

(2) Adverse benefit determination procedures for health insurance policies and health maintenance organization contracts shall be established in accordance [~~Section~~] Sections 31A-22-629 and 31A-22-650.

Section 3. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance.

(1) (a) This section applies to all health benefit plans.

(b) Subsection (2) applies to:

(i) all health benefit plans; and

(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to provide to all enrollees, before enrollment in the health benefit plan, written disclosure of:

(a) restrictions or limitations on prescription drugs and biologics, including:

(i) the use of a formulary;

(ii) co-payments and deductibles for prescription drugs; and

(iii) requirements for generic substitution;

(b) coverage limits under the plan;

(c) any limitation or exclusion of coverage, including:

(i) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

(ii) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition;

(d) (i) (A) each drug, device, and covered service that is subject to a preauthorization requirement as defined in Section 31A-22-650; or

(B) if listing each device or covered service in accordance with Subsection (2)(d)(i)(A) is too numerous to list separately, all devices or covered services in a particular category where all devices or covered services have the same preauthorization requirement;

(ii) each requirement for authorization as defined in Section 31A-22-650 for:

(A) each drug, device, or covered service described in Subsection (2)(d)(i)(A); and

(B) each category of devices or covered services described in Subsection (2)(d)(i)(B); and

(iii) sufficient information to allow a network provider or enrollee to submit all of the information to the insurer necessary to meet each requirement for authorization described in Subsection (2)(d)(ii);

[~~(d)~~] (e) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits; and

[~~(e)~~] (f) whether the insurer provides coverage for telehealth services in accordance with Section 26-18-13.5 and terms associated with that coverage.

(3) An insurer shall provide the disclosure required by Subsection (2)[~~(a)(i)~~] in writing to the commissioner:

(a) upon commencement of operations in the state; and

(b) anytime the insurer amends any of the following described in Subsection (2):

(i) treatment policies;

(ii) practice standards;

(iii) restrictions;

(iv) coverage limits of the insurer's health benefit plan or health insurance policy; or

(v) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

(4) (a) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a):

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

(b) If under Subsection (2)(a) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

(c) [~~(i)~~] The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(c).

[~~(ii)~~] (5) Examples of a limitation or exclusion of coverage provided under [~~Subsection (2)(c)~~] this section or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(6) An insurer shall:

(a) post the information described in Subsection (2)(d) on the insurer's website and provider portal;

(b) if requested by an enrollee, provide the enrollee with the information required by this section by mail or email; and

(c) if requested by a network provider for a specific drug, device, or covered service,

provide the network provider with the information described in Subsection (2)(d) for the drug, device or covered service by mail or email.

Section 4. Section **31A-22-650** is enacted 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 Ŝ→ **:**

(i) ←Ŝ 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 Ŝ→ **[.] ;**

and

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

(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) Before April 1, 2021, and before April 1 of each year thereafter, 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.

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

Section 5. **Effective date.**

This bill takes effect on January 1, 2020.