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1 # MEDICAL TREATMENT AUTHORIZATION AMENDMENTS

2 2019 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Evan J. Vickers**

5 House Sponsor: Suzanne Harrison

6

7 **LONG TITLE**

8 **General Description:**

9 This bill enacts provisions relating to authorization of health care.

10 **Highlighted Provisions:**

11 This bill:

12 ▸ defines terms;

13 ▸ requires an insurer to post certain information regarding requirements for the

14 authorization for health care;

15 ▸ prohibits an insurer from denying certain requests for authorization of health care;

16 ▸ requires an insurer to respond to a request for authorization for health care within a

17 certain time period;

18 ▸ creates requirements when an insurer changes certain policies in the middle of a

19 plan year; and

20 ▸ creates a reporting requirement.

21 **Money Appropriated in this Bill:**

22 None

23 **Other Special Clauses:**

24 None

25 **Utah Code Sections Affected:**

26 ENACTS:

27 **31A-22-650**, Utah Code Annotated 1953

S.B. 264

28
29 *Be it enacted by the Legislature of the state of Utah:*
30 Section 1. Section **31A-22-650** is enacted to read:
31 **31A-22-650. Health care authorization -- Preauthorization requirements.**
32 (1) As used in this section:
33 (a) "Adverse determination" means a determination by an insurer that health care does
34 not meet the requirements for authorization.
35 (b) "Authorization" means a determination by an insurer that:
36 (i) proposed health care meets all requirements, restrictions, limitations, and clinical
37 criteria for authorization established by the insurer;
38 (ii) the health care is covered by the enrollee's insurance policy; and
39 (iii) the insurer will provide coverage for the health care subject to the provisions of the
40 insurance policy, including any cost sharing responsibilities of the enrollee.
41 (c) "Device" means a prescription device as defined in Section 58-17b-102.
42 (d) "Drug" means the same as that term is defined in Section 58-17b-102.
43 (e) "Emergency health care" means health care provided for an emergency condition as
44 defined in Section 31A-22-627.
45 (f) "Insurer" means the same as that term is defined in Section 31A-22-634.
46 (g) "Preauthorization requirement" means a requirement by an insurer that an enrollee
47 obtain authorization for a drug, device, or service covered by the insurance policy, before
48 receiving the drug, device, or service.
49 (h) "Urgent health care" means health care that:
50 (i) is not emergency health care; and
51 (ii) in the opinion of a physician with knowledge of the enrollee's medical condition, if
52 the health care is not provided within 24 hours:
53 (A) could seriously jeopardize the life or health of the enrollee or the ability of the
54 enrollee to regain maximum function; or
55 (B) would subject the enrollee to severe pain that cannot be adequately managed
56 without the health care.
57 (2) (a) An insurer shall provide:
58 (i) the insurer's providers and enrollees with a list of each drug, device, and service that

59 is subject to a preauthorization requirement; and
60 (ii) the insurer's providers with sufficient information to allow a provider or enrollee to
61 submit all of the information to the insurer necessary to meet the insurer's requirements for
62 authorization.
63 (b) An insurer shall provide the information described in Subsection (2)(a):
64 (i) in language that is easy to understand;
65 (ii) with sufficient detail to provide an understanding of the insurer's requirements; and
66 (iii) on a website that is easily accessible to the insurer's providers and enrollees.
67 (c) An insurer may not deny authorization to an enrollee based on the failure of an
68 enrollee or provider to meet a requirement for authorization if the requirement for authorization
69 is not provided to the insurer's enrollees and providers in accordance with Subsection (2)(a).
70 (3) (a) An insurer may not modify an existing preauthorization requirement unless, at
71 least 30 days before the day on which the modification takes effect, the insurer:
72 (i) posts a notice of the modification on the website described in Subsection (2)(b)(iii);
73 and
74 (ii) if requested by a provider or the provider's representative, provides to the provider
75 by mail or electronic mail a written notice of modification to a particular preauthorization
76 requirement described in the request from the provider.
77 (b) If an enrollee requests a written notice of a modification to a particular
78 preauthorization requirement, an insurer shall provide the enrollee with the written notice:
79 (i) by mail or electronic mail; and
80 (ii) in accordance with standards established by the department by rule made in
81 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
82 (c) Subsection (3)(b) does not apply if:
83 (i) complying with Subsection (3)(b) would create a danger to the enrollee's health or
84 safety; or
85 (ii) the modification is for a newly covered drug or device.
86 (d) An insurer may not revoke an authorization for health care if:
87 (i) the provider submits a request for authorization for the health care to the insurer;
88 (ii) the insurer grants the authorization requested under Subsection (3)(d)(i);
89 (iii) the provider renders the health care to the enrollee in accordance with the

90 authorization and any terms and conditions of the provider's contract with the insurer;
91 (iv) on the day on which that the provider renders the health care to the enrollee:
92 (A) the enrollee is eligible for coverage under the enrollee's insurance policy; and
93 (B) the enrollee's condition or circumstances related to the enrollee's care have not
94 changed;
95 (v) the provider submits an accurate claim that matches the information in the request
96 for authorization under Subsection (3)(d)(i); and
97 (vi) the authorization was not based on fraudulent or materially incorrect information
98 from the provider.
99 (4) (a) An insurer that receives a request for authorization shall notify the person
100 making the request regarding the insurer's authorization or adverse determination:
101 (i) as soon as possible, taking medical exigencies into account; and
102 (ii) (A) if the request is for authorization of urgent health care or health care that is
103 required immediately after the provision of emergency health care, before the later of 72 hours
104 after the insurer receives the request or one business day after the day on which the insurer
105 receives the request; or
106 (B) for a request for authorization of health care that is not described in Subsection
107 (4)(a)(ii), within 15 business days after the day on which the insurer receives a request for
108 authorization that includes all clinical information that a health care provider would need to
109 render a clinical judgment.
110 (b) If a request for authorization is missing information required by an insurer, the
111 insurer shall notify the person making the request of the specific missing information within
112 the applicable time period described in Subsection (4)(a).
113 (c) (i) In a notification of adverse determination, an insurer shall specify each reason
114 for the adverse determination, including a reference to any specific information necessary to
115 meet the insurer's requirements for authorization.
116 (ii) If a provider submits a request for authorization to an insurer that includes an
117 unintentional error that results in a denial of the claim, the insurer shall permit the provider
118 with an opportunity to resubmit the claim with corrected information within a reasonable
119 amount of time.
120 (d) The appeal of an adverse determination regarding clinical or medical necessity as

121 requested by a physician may only be reviewed by a physician:
122 (i) as defined in Section 58-67-102; or
123 (ii) who is currently licensed as a physician or surgeon in another state, district, or
124 territory of the United States.
125 (e) An insurer shall ensure that an adverse determination is made by an individual who:
126 (i) has knowledge of the medical condition or disease of the enrollee for whom the
127 authorization is requested; or
128 (ii) consults with a specialist who has knowledge of the medical condition or disease of
129 the enrollee for whom the authorization is requested regarding the request before making the
130 determination.
131 (f) An insurer shall specify how long an authorization is valid.
132 (5) (a) An insurer that removes a drug from the insurer's formulary shall permit an
133 enrollee, an enrollee's designee, or an enrollee's health care provider to request an exemption
134 from the change to the formulary for the purpose of providing the patient with continuity of
135 care.
136 (b) If an insurer makes a change to the formulary for a drug in the middle of a plan
137 year, the insurer may not implement the changes for an enrollee that is on an active course of
138 treatment for the drug unless the insurer provides the enrollee with notice at least 30 days
139 before the day on which the change is implemented.
140 (6) (a) Beginning April 1, 2020, an insurer with a preauthorization requirement shall
141 report to the department, within 30 days after the day on which each calendar quarter ends:
142 (i) for the previous calendar quarter, the number of authorizations or adverse
143 determinations that were provided more than one week after the day on which the insurer
144 received the request for authorization; and
145 (ii) the information described in Subsection (6)(a)(i) as a percentage of all
146 authorizations or adverse determinations made by the insurer in the calendar quarter.
147 (b) The department shall make the reported percentages described in Subsection
148 (6)(a)(ii) available to the public upon request.
149 (7) An insurer may not have a preauthorization requirement for emergency health care
150 as described in Section 31A-22-627.
151 (8) This section applies to a health benefit plan entered into or renewed on or after

152 January 1, 2020.