



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

**“Ensuring Transparency in Prior Authorization Act”**

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

**Section I. Title:** This Act may be known and cited as the “Ensuring Transparency in Prior Authorization Act.”

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

(a) The patient-physician relationship is paramount and should not be subject to third-party intrusion;

(b) Prior authorization programs place cost savings ahead of optimal patient care; and

(c) Prior authorization programs shall not be permitted to hinder patient care or intrude on the practice of medicine.

**Section III. Definitions.**

a) **“Adverse determination”** means a decision by a utilization review entity that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary, or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated. A decision to deny, reduce, or terminate services that are not covered for reasons other than their medical necessity or experimental or investigational nature is not an “adverse determination” for purposes of this Act.

- 1       b) **“Authorization”** means a determination by a utilization review entity that a health care  
2       service has been reviewed and, based on the information provided, satisfies the utilization  
3       review entity’s requirements for medical necessity and appropriateness and that payment  
4       will be made for that health care service.
- 5       c) **“Clinical criteria”** means the written policies, written screening procedures, drug  
6       formularies or lists of covered drugs, determination rules, determination abstracts,  
7       clinical protocols, practice guidelines, medical protocols and any other criteria or  
8       rationale used by the utilization review entity to determine the necessity and  
9       appropriateness of health care services.
- 10      d) **“Emergency health care services”** means those health care services that are provided in  
11      an emergency facility after the sudden onset of a medical condition that manifests itself  
12      by symptoms of sufficient severity, including severe pain, that the absence of immediate  
13      medical attention could reasonably be expected by a prudent layperson, who possesses an  
14      average knowledge of health and medicine, to result in: (i) placing the patient's health in  
15      serious jeopardy; (ii) serious impairment to bodily function; or (iii) serious dysfunction of  
16      any bodily organ or part.
- 17      e) **“Health care service”** means health care procedures, treatments or services: (i) provided  
18      by a facility licensed in (indicate the name of the state); or (ii) provided by a doctor of  
19      medicine, a doctor of osteopathy, or within the scope of practice for which a health care  
20      professional is licensed in (indicate the name of the state). The term “health care service”  
21      also includes the provision of pharmaceutical products or services or durable medical  
22      equipment.

- 1 f) **“Medically necessary health care services”** means health care services that a prudent  
2 physician would provide to a patient for the purpose of preventing, diagnosing or treating  
3 an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with  
4 generally accepted standards of medical practice; (ii) clinically appropriate in terms of  
5 type, frequency, extent, site and duration; and (iii) not primarily for the economic benefit  
6 of the health plans and purchasers or for the convenience of the patient, treating  
7 physician, or other health care provider.
- 8 g) **“Medications for opioid use disorder (MOUD)”** means the use of medications,  
9 commonly in combination with counseling and behavioral therapies, to provide a  
10 comprehensive approach to the treatment of opioid use disorder. FDA-approved  
11 medications used to treat opioid addiction include methadone, buprenorphine (alone or in  
12 combination with naloxone) and extended-release injectable naltrexone. Types of  
13 behavioral therapies include individual therapy, group counseling, family behavior  
14 therapy, motivational incentives and other modalities.
- 15 h) **“NCPDP SCRIPT Standard”** means the National Council for Prescription Drug  
16 Programs SCRIPT Standard Version 2017071, or the most recent standard adopted by the  
17 United States Department of Health and Human Services (HHS). Subsequently released  
18 versions of the NCPDP SCRIPT Standard may be used.
- 19 i) **“Prior authorization”** means the process by which utilization review entities determine  
20 the medical necessity and/or medical appropriateness of otherwise covered health care  
21 services prior to the rendering of such health care services. “Prior authorization” also  
22 includes any health insurer’s or utilization review entity’s requirement that an enrollee or

1 health care provider notify the health insurer or utilization review entity prior to  
2 providing a health care service.

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

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

- 9 i. could seriously jeopardize the life or health of the enrollee or the ability of the  
10 enrollee to regain maximum function; or
- 11 ii. could subject the enrollee to severe pain that cannot be adequately managed  
12 without the care or treatment that is the subject of the utilization review.

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

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

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

1 person treated by a health care professional in \_\_\_\_\_ (*indicate name of state*)  
2 under a policy, plan, or contract.

3 **Section IV. Disclosure and review of prior authorization requirements.**

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

8 a) If a utilization review entity intends either to implement a new prior authorization  
9 requirement or restriction, or amend an existing requirement or restriction, the utilization  
10 review entity shall ensure that the new or amended requirement is not implemented  
11 unless the utilization review entity's Web site has been updated to reflect the new or  
12 amended requirement or restriction.

13 b) If a utilization review entity intends either to implement a new prior authorization  
14 requirement or restriction, or amend an existing requirement or restriction, the utilization  
15 review entity shall provide contracted health care providers of enrollees written notice of  
16 the new or amended requirement or amendment no less than sixty (60) days before the  
17 requirement or restriction is implemented.

18 c) Entities using prior authorization shall make statistics available regarding prior  
19 authorization approvals and denials on their Web site in a readily accessible format.

20 They should include categories for:

21 (i) Physician specialty;

22 (ii) Medication or diagnostic test/procedure;

- (iii) Indication offered;
- (iv) Reason for denial;
- (v) if appealed;
- (vi) if approved or denied on appeal;
- (vii) the time between submission and the response.

**Section V. Personnel qualified to make adverse determinations.** A utilization review entity must ensure that all adverse determinations are made by a physician. The physician must:

- a) possess a current and valid non-restricted license to practice medicine in \_\_\_\_\_ (*the state in which the proposed services would have been provided if authorized*);
- b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request;
- c) have experience treating patients with the medical condition or disease for which the health care service is being requested; and
- d) make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of health care services provided to enrollees of \_\_\_\_\_ (*state in which the proposed health care items or services would have been provided if authorized*). All such medical directors must be physicians licensed in \_\_\_\_\_ (*the state in which the proposed health care items or services would have been provided if authorized*).

**Section VI. Consultation prior to issuing an adverse determination.** If a utilization review entity is questioning the medical necessity of a health care service, the utilization review entity

1 must notify the enrollee's physician that medical necessity is being questioned. Prior to issuing  
2 an adverse determination, the enrollee's physician must have the opportunity to discuss the  
3 medical necessity of the health care service on the telephone with the physician who will be  
4 responsible for determining authorization of the health care service under review.

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

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

utilization review entity by a health care facility, and any medical literature provided to the utilization review entity by the health care provider.

**Section VIII. Utilization review entity's obligations with respect to prior authorizations in**

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

**Section IX. Utilization review entities' obligations with respect to prior authorizations**

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

**Section X. Utilization review entity's obligations with respect to prior authorization**

**concerning emergency health care services.**

a) A utilization review entity cannot require prior authorization for pre-hospital transportation or for the provision of emergency health care services.

b) A utilization review entity shall allow an enrollee and the enrollee's health care provider a minimum of twenty-four (24) hours following an emergency admission or provision of



1 emergency health care services for the enrollee or health care provider to notify the  
2 utilization review entity of the admission or provision of health care services. If the  
3 admission or health care service occurs on a holiday or weekend, a utilization review  
4 entity cannot require notification until the next business day after the admission or  
5 provision of the health care services.

6 c) A utilization review entity shall cover emergency health care services necessary to screen  
7 and stabilize an enrollee. If a health care provider certifies in writing to a utilization  
8 review entity within seventy-two (72) hours of an enrollee's admission that the enrollee's  
9 condition required emergency health care services, that certification will create a  
10 presumption that the emergency health care services were medically necessary and such  
11 presumption may be rebutted only if the utilization review entity can establish, with clear  
12 and convincing evidence, that the emergency health care services were not medically  
13 necessary.

14 d) The medical necessity or appropriateness of emergency health care services cannot be  
15 based on whether those services were provided by participating or nonparticipating  
16 providers. Restrictions on coverage of emergency health care services provided by  
17 nonparticipating providers cannot be greater than restrictions that apply when those  
18 services are provided by participating providers.

19 e) If an enrollee receives an emergency health care service that requires immediate post  
20 evaluation or post-stabilization services, a utilization review entity shall make an  
21 authorization determination within sixty (60) minutes of receiving a request; if the

1 authorization determination is not made within sixty (60) minutes, such services shall be  
2 deemed approved.

3 **Section XI. No prior authorization for MOUD.** A utilization review entity may not require prior  
4 authorization for the provision of MOUD.

5 **Section XII. Retrospective denial.**

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

9 b) A utilization review entity must pay a health care provider at the contracted payment rate  
10 for a health care service provided by the health care provider per a prior authorization unless:

11 (i) the health care provider knowingly and materially misrepresented the health care  
12 service in the prior authorization request with the specific intent to deceive and obtain  
13 an unlawful payment from utilization review entity;

14 (ii) The health care service was no longer a covered benefit on the day it was provided;

15 (iii) The health care provider was no longer contracted with the patients' health  
16 insurance plan on the date the care was provided;

17 (iv) The health care provider failed to meet the utilization review entity's timely filing  
18 requirements;

19 (v) The utilization review entity does not have liability for a claim; or

20 (vi) The patient was no longer eligible for health care coverage on the day the care was  
21 provided.

**Section XIII. Length of prior authorization.** A prior authorization shall be valid for one year from the date the health care provider receives the prior authorization and the authorization period shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider. *[Drafting Note: States may want to connect this provision for prescription drugs to the statutory length of a prescription under their Pharmacy Practice Act, if it is greater than one year.]*

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

**Section XV: Continuity of care for enrollees.**

- a) On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial 60 days of an enrollee's coverage under a new health plan.
- b) During the time period described in paragraph (a) of this subsection, a utilization review entity may perform its own review to grant a prior authorization.
- c) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.
- d) A utilization review entity shall continue to honor a prior authorization it has granted to

an enrollee when the enrollee changes products under the same health insurance company.

**Section XVI. Provider exemptions from prior authorization requirements.**

a) A utilization review entity may not require a health care provider to complete a prior authorization for a health care service in order for the enrollee to whom the service is being provided to receive coverage if in the most recent 12-month period, the utilization review entity has approved or would have approved not less than 80 percent of the prior authorization requests submitted by the health care provider for that health care service.

b) A utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as described in Subsection (a) not more than once every 12 months. Nothing in this Section requires a utilization review entity to evaluate an existing exemption or prevents a utilization review entity from establishing a longer exemption period.

c) A health care provider is not required to request an exemption in order to qualify for an exemption.

d) A health care provider who does not receive an exemption may request from the utilization review entity at any time, but not more than once per year per service, evidence to support the utilization review entity's decision. A health care provider may appeal a utilization review entity's decision to deny an exemption.

e) A utilization review entity may only revoke an exemption at the end of the 12-month period if the utilization review entity:

(i) makes a determination that the health care provider would not have met the 80 percent approval criteria based on a retrospective review of the claims for the

1 particular service for which the exemption applies for the previous 3 months, or for a  
2 longer period if needed to reach a minimum of 10 claims for review;

3 (ii) provides the health care provider with the information it relied upon in making its  
4 determination to revoke the exemption; and

5 (iii) provides the health care provider a plain language explanation of how to appeal  
6 the decision.

7 f) An exemption remains in effect until the 30th day after the date the utilization review  
8 entity notifies the health care provider of its determination to revoke the exemption or, if  
9 the health care provider appeals the determination, the fifth day after the revocation is  
10 upheld on appeal.

11 g) A determination to revoke or deny an exemption must be made by a health care provider  
12 licensed in [state] of the same or similar specialty as the health care provider being  
13 considered for an exemption and have experience in providing the service for which the  
14 potential exemption applies.

15 h) A utilization review entity must provide a health care provider that receives an  
16 exemption a notice that includes:

17 (i) A statement that the health care provider qualifies for an exemption from  
18 preauthorization requirements;

19 (ii) A list of services for which the exemption(s) apply; and

20 (iii) A statement of the duration of the exemption.

21 i) A utilization review entity shall not deny or reduce payment for a health care service  
22 exempted from a prior authorization requirement under this section, including a health care  
23 service performed or supervised by another health care provider when the health care

1 provider who ordered such service received a prior authorization exemption, unless the  
2 rendering health care provider: (1) knowingly and materially misrepresented the health care  
3 service in request for payment submitted to the utilization review entity with the specific  
4 intent to deceive an obtain an unlawful payment from utilization review entity; or (2) failed  
5 to substantially perform the health care service.

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

12 **Section XVIII. Health care services deemed authorized if a utilization review entity fails to**  
13 **comply with the requirements of this Act.** Any failure by a utilization review entity to comply  
14 with the deadlines and other requirements specified in this Act will result in any health care  
15 services subject to review to be automatically deemed authorized by the utilization review entity.

16 **Section XIX. Severability.** If any provision of this Act or the application thereof to any person  
17 or circumstance is held invalid, such invalidity shall not affect other provisions or applications of  
18 the Act which can be given effect without the invalid provision or application, and to this end the  
19 provisions of this Act are declared to be severable.