Prior Authorization Model Legislation

NEW SECTION. Section 1. Insert this section in the title, subtitle, chapter, or subchapter of the insurance code that pertains to health insurance coverage or utilization review.

Italics indicate terms that will vary by state

(a) This section applies to:

(1) An *accident and sickness insurer, a health service corporation, a medical service corporation, a health maintenance organization*, and any other entity providing *health benefit plans*.

(2) A third-party administrator or other entity that adjusts, administers, or settles claims in connection with *health benefit plans*, including, but not limited to, a pharmacy benefits manager and managed behavioral health organization.

(3) A person who contracts with an entity described in this section to issue prior authorization determinations or perform the functions described in this section.

(b) An entity subject to this section shall not perform prior authorization on *health benefits* under the following circumstances:

(1) For generic prescription drugs that are not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found at § XXXX through § XXXX of the *state criminal law title*.

(2) For any prescription drug, generic or brand name, that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found at § XXXX through § XXXX of the *state criminal law* title after an insured or enrollee has been prescribed the drug without interruption for six months.

(3) For any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication if the insured or enrollee has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of such prescription drug or drugs and coverage of such prescription drug or drugs was approved.

(4) For any prescription drug, generic or brand name, solely because the dosage of the medication for the insured or enrollee has been adjusted by the prescriber of such prescription drug.

(5) For any prescription drug, generic or brand name, that is a long-acting injectable.

(c) Any denial of coverage for a prescription drug made during the course of prior authorization by an entity subject to this section shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in a denial of coverage shall not require the involvement of a physician on the part of an entity subject to this section.

(d) An entity subject to this section shall not perform retrospective review on any *health benefits* under the following circumstances:

(1) When payment has already been furnished to the provider of a *health benefit* unless the entity has a credible reason or reasons to believe that fraud or other illegal activity may have occurred involving such *health benefit* for which payment has been furnished.

(2) When a *health benefit* has been previously approved and deemed medically necessary during prior authorization or concurrent review, provided that the entity may perform retrospective review if such *health benefit* was delivered in a manner that exceeded the scope or duration of what was approved during prior authorization or concurrent review.

(3) Retrospectively reviewing approved, paid, or pending claims or authorizations of *health benefits* for the purposes of informing future utilization review activities shall not be considered a form of retrospective review.

NEW SECTION. Section 2. Insert this section in the title, subtitle, chapter, or subchapter of the insurance code that pertains to health insurance appeals or grievances.

(a) Any denial of coverage for a prescription drug made during the course of prior authorization shall be eligible for an expedited internal appeal process if the prescriber of the prescription drug subject to prior authorization believes that, in his or her professional judgment, the insured or enrollee will suffer serious harm without access to the prescription drug subject to prior authorization.

(b) Upon initiation of the expedited internal appeal process by the prescriber of the prescription drug subject to prior authorization, an entity subject to this section shall render a decision on the expedited internal appeal within 48 hours and provide written notice.

(c) If an entity subject to this section does not render a decision on the expedited internal appeal initiated by the prescriber of the prescription drug subject to prior authorization within 48 hours of initiation, the initial denial of coverage shall be automatically overturned and the insured or enrollee shall be granted immediate approval for coverage of the prescription drug subject to prior authorization.

(d) The decision rendered during the expedited appeal process by the entity subject to this section shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, but shall not be the same physician that rendered the initial denial of coverage for the prescription drug subject to prior authorization.

NEW SECTION. Section 3. Insert this section in the title, subtitle, chapter, or subchapter of the insurance code that pertains to health insurance coverage or utilization review.

(a) This section applies to:

(1) An *accident and sickness insurer, a health service corporation, a medical service corporation, a health maintenance organization*, and any other entity providing *health benefit plans.*

(2) A third-party administrator or other entity that adjusts, administers, or settles claims in connection with *health benefit plans*, including, but not limited to, a pharmacy benefits manager and managed behavioral health organization.

(3) A person who contracts with an entity described in this section to issue prior authorization determinations or perform the functions described in this section.

(b) An entity subject to this section that uses a prior authorization process for *health benefits* may not require a physician or provider to obtain prior authorization for a particular *health benefit* if, in the most recent six-month evaluation period, as described in subsection (c), the entity has approved or would have approved not less than 90 percent of the prior authorization requests submitted by the physician or provider for the particular *health benefit*.

(c) Except as provided by Subsection (d), an entity subject to this section shall evaluate whether a physician or provider qualifies for an exemption from prior authorization requirements under subsection (b) once every six months.

(d) An entity subject to this section may continue an exemption under subsection (b) without evaluating whether the physician or provider qualifies for the exemption under subsection (b) for a particular evaluation period.

(e) A physician or provider is not required to request an exemption under subsection (b) to qualify for the exemption.

(f) A physician's or provider's exemption from prior authorization requirements under subsection (b) remains in effect until:

(1) The 30th day after the date the entity subject to this section notifies the physician or provider of the entity's determination to rescind the exemption under subsection (b), if the physician or provider does not appeal the entity's determination; or

(2) If the physician or provider appeals the determination, the fifth day after the date an independent review organization affirms the entity's determination to rescind the exemption.

(g) If an entity subject to this section does not finalize a rescission determination as specified in subsection (f), then the physician or provider is considered to have met the criteria under subsection (b) to continue to qualify for the exemption.

(h) An entity subject to this section may rescind an exemption from prior authorization requirements under subsection (b) only:

(1) During January or June of each year;

(2) If the entity makes a determination, on the basis of a retrospective review of a random sample of not fewer than 20 and no more than 50 claims submitted by the physician or provider during the most recent evaluation period described by subsection (c), that less than 90 percent of the claims for the particular *health benefit* met the medical necessity criteria that would have been used by the entity when conducting prior authorization review for the particular *health benefit* during the relevant evaluation period; and

(3) If the entity complies with other applicable requirements specified in this section, including:

(A) Notifying the physician or provider not less than 25 days before the proposed rescission is to take effect; and

(B) Providing with the notice under subparagraph (A):

(i) the sample information used to make the determination under paragraph (2); and

(ii) a plain language explanation of how the physician or provider may appeal and seek an independent review of the determination.

(i) A determination made under subsection (h)(2) must be made by an individual licensed to practice medicine in this state. For a determination made under subsection (h)(2) with respect to a

physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

(j) An entity subject to this section may deny an exemption from prior authorization requirements under subsection (b) only if:

(1) The physician or provider does not have the exemption at the time of the relevant evaluation period; and

(2) The entity provides the physician or provider with actual statistics and data for the relevant prior authorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider does not meet the criteria for an exemption from prior authorization requirements for the particular *health benefit* under subsection (b).

(k) An entity subject to this section may not deny or reduce payment to a physician or provider for a *health benefit* for which the physician or provider has qualified for an exemption from prior authorization requirements under subsection (b) based on medical necessity or appropriateness of care unless the physician or provider:

(1) Knowingly and materially misrepresented the *health benefit* in a request for payment submitted to the entity with the specific intent to deceive and obtain an unlawful payment from the entity; or

(2) Failed to substantially furnish or deliver the *health benefit*.

(l) An entity subject to this section may not conduct a retrospective review of a *health benefit* subject to an exemption except:

(1) To determine if the physician or provider still qualifies for an exemption under this section; or

(2) If the entity has a reasonable cause to suspect a basis for denial exists under subsection (k).

(m) Not later than five days after qualifying for an exemption from prior authorization requirements under subsection (b), an entity subject to this section must provide to a physician or provider a notice that includes:

(1) A statement that the physician or provider qualifies for an exemption from prior authorization requirements under subsection (b);

(2) A list of the *health benefits* and *health benefit plans* to which the exemption applies; and

(3) A statement of the duration of the exemption.

(n) If a physician or provider submits a prior authorization request for a *health benefit* for which the physician or provider qualifies for an exemption from prior authorization requirements under subsection (b), the entity subject to this section must promptly provide a notice to the physician or provider that includes:

(1) The information described by subsection (m); and

(2) A notification of the entity's payment requirements.

(o) Nothing in this section may be construed to:

(1) Authorize a physician or provider to provide a *health benefit* outside the scope of the provider 's applicable license issued under *Title X, of the Occupations and Professions Code*; or

(2) Require an entity subject to this section to pay for a *health benefit* that is performed in violation of the *laws of this state*.

NEW SECTION. Section 4. Insert this section in the title, subtitle, chapter, or subchapter of the insurance code that pertains to health insurance external review.

(a) This section applies to:

(1) An *accident and sickness insurer, a health service corporation, a medical service corporation, a health maintenance organization*, and any other entity providing *health benefit plans*.

(2) A third-party administrator or other entity that adjusts, administers, or settles claims in connection with *health benefit plans*, including, but not limited to, a pharmacy benefits manager and managed behavioral health organization.

(3) A person who contracts with an entity described in this section to issue prior authorization determinations or perform the functions described in this section.

(b) A physician or provider has the right to a review of an adverse determination regarding a prior authorization exemption under section 3 be conducted by an independent review organization. An entity subject to this section may not require a physician or provider to engage in an internal appeal process before requesting a review by an independent review organization under this section.

(c) An entity subject to this section shall pay:

(1) For any appeal or independent review of an adverse determination regarding a prior authorization exemption requested under this section; and

(2) A reasonable fee determined by the *State Medical Board* for any copies of medical records or other documents requested from a physician or provider during an exemption rescission review requested under this section.

(d) An independent review organization must complete an expedited review of an adverse determination regarding a prior authorization exemption not later than the 7th day after the date a physician or provider files the request for a review under this section.

(e) A physician or provider may request that the independent review organization consider another random sample of not less than 20 and no more than 50 claims submitted to the entity subject to this section by the physician or provider during the relevant evaluation period for the relevant *health benefit* as part of its review. If the physician or provider makes a request under this subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the entity under subsection (h) of section 3 and reviewed under this subsection.

(f) An entity subject to this section is bound by an appeal or independent review determination that does not affirm the determination made by the entity to rescind a prior authorization exemption.

(g) An entity subject to this section may not retrospectively deny a *health benefit* on the basis of a rescission of an exemption, even if the entity's determination to rescind the prior authorization exemption is affirmed by an independent review organization.

(h) If a determination of a prior authorization exemption made by the entity subject to this section is overturned on review by an independent review organization, the entity:

(1) May not attempt to rescind the exemption before the end of the next evaluation period that occurs; and

(2) May only rescind the exemption after if the entity complies with the previous provisions of this section and subsections (h), (i), and (j) of section 3.