Senate Bill 80

By: Senators Kirkpatrick of the 32nd, Burke of the 11th, Watson of the 1st, Walker III of the 20th, Harbison of the 15th and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for standards for utilization review; to provide for statutory construction; to provide for applicability; to provide for definitions; to provide for a short title; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act."

SECTION 2.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

"33-66-1.

This chapter shall be construed liberally to promote consumer protection.

33-66-2.

This chapter applies to:

(1) All health insurers that provide accident and sickness insurance products whether on an individual, group, or blanket basis as provided in this title;

(2) All administrators of such products licensed in accordance with Article 2 of Chapter 23 of this title; and

(3) All pharmacy benefits managers.

33-66-3.

As used in this chapter, the term:

(1) 'Adverse determination' means a decision by a utilization review entity that the healthcare 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. Such term shall not mean a decision to deny, reduce, or terminate services that are not covered for reasons other than their medical necessity or experimental or investigational nature.

(2) 'Authorization' means a determination by a utilization review entity that a healthcare service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness.

(3) 'Clinical criteria' means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of healthcare services.

(4) 'Emergency healthcare services' means those healthcare services that occur after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention

could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily function; or

(C) Serious dysfunction of any bodily organ or part.

(5) 'Enrollee' means an individual eligible to receive healthcare benefits by a health insurer pursuant to a healthcare plan or other health insurance coverage. Such term shall include an enrollee's legally authorized representative.

(6) 'Facility' means a hospital, ambulatory surgical center, birthing center, diagnostic and treatment center, hospice, or similar institution. Such term shall not mean a healthcare provider's office.

(7) 'Health insurer' or 'insurer' means an accident and sickness insurer, healthcare corporation, health maintenance organization, provider sponsored healthcare corporation, or any similar entity regulated by the Commissioner.

(8) 'Healthcare service' means healthcare procedures, treatments, or services provided by a facility licensed in this state or provided within the scope of practice of a doctor of medicine, a doctor of osteopathy, or another healthcare provider licensed in this state. Such term includes but is not limited to the provision of pharmaceutical products or services or durable medical equipment.

(9) 'Indication' means the basis for initiating treatment for a disease or a diagnostic test.

(10) 'Medically necessary healthcare services' means healthcare services that a prudent physician or other healthcare provider would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a manner that is:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the health insurer or for the convenience of the patient, treating physician, or other healthcare provider.

(11) 'Pharmacy benefits manager' means a person, business entity, or other entity that performs pharmacy benefits management. Such term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a healthcare plan. Such term shall not include services provided by pharmacies operating under a hospital pharmacy license. Such term shall not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. Such term shall not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(12) 'Prior authorization' means the process by which a utilization review entity determines the medical necessity or medical appropriateness of otherwise covered healthcare services prior to the rendering of such services. Such term shall include any health insurer's or utilization review entity's requirement that an enrollee or healthcare provider notify the health insurer or utilization review entity prior to providing a healthcare service.

(13) 'Urgent healthcare service' means a healthcare service with respect to which the application of the time periods for making a nonexpedited prior authorization, which, in the opinion of a physician or other healthcare provider with knowledge of the enrollee's medical condition:

(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 care or treatment that is the subject of the utilization review.

Such term shall include services provided for the treatment of substance use disorders which otherwise qualify as an urgent healthcare service.

(14) 'Utilization review entity' means an individual or entity that performs prior authorization for one or more of the following entities:

(A) An insurer that writes health insurance policies;

(B) A preferred provider organization or health maintenance organization; and

(C) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a person treated by a healthcare provider in this state under a policy, plan, or contract.

33-66-4.

(a) A utilization review entity shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, healthcare providers, and the general public, including but not limited to written clinical criteria. Requirements shall be described in detail and in easily understandable language.

(b) If a utilization review entity intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, such entity shall ensure that the new or amended requirement or restriction is not implemented unless such entity's website has been updated to reflect such addition or change.

(c) If a utilization review entity intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the utilization review entity shall provide contracted healthcare providers of enrollees written notice of the new or amended requirement or restriction no less than 60 days before such addition or change is implemented.

(d) A utilization review entity using prior authorization shall make statistics available regarding prior authorization approvals and denials on its website in a readily accessible format. Such statistics shall include categories for:

(1) Physician speciality;

(2) Medication or diagnostic tests and procedures;

(3) Indication offered;

(4) Reason for denial;

(5) Whether appealed;

(6) Whether approved or denied on appeal; and

(7) Time between submission and response.

33-66-5.

A utilization review entity shall ensure that all adverse determinations are made by a physician who shall possess a current and valid nonrestricted license to practice medicine in this state and who shall:

(1) Be of the same specialty as the physician who typically manages the medical condition or disease or provides the healthcare service involved in the request; or

(2) Have experience treating patients with the medical condition or disease for which the healthcare service is being requested.

33-66-6.

If a utilization review entity questions the medical necessity of a healthcare service, such entity shall notify the enrollee's physician or other medical professional that medical necessity is being questioned. Prior to issuing an adverse determination, the enrollee's physician shall have the opportunity to discuss the medical necessity of the healthcare service on the telephone or through synchronous digital text or voice messaging or similar technology with the physician who will be responsible for determining authorization of the healthcare service under review.

33-66-7.

A utilization review entity shall ensure that all appeals are reviewed by a physician who shall:

(1) Possess a current and valid nonrestricted license to practice medicine in this state;

(2) Be currently in active practice in the same or similar specialty as a physician who typically manages the medical condition or disease for at least five consecutive years;

(3) Be knowledgeable of, and have experience providing, the healthcare services under appeal;

(4) Not be employed by a utilization review entity or be under contract with a utilization review entity other than to participate in one or more of the utilization review entity's healthcare provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

(5) Not have been directly involved in making the adverse determination; and

(6) Consider all known clinical aspects of the healthcare service under review, including, but not limited to, a review of all pertinent medical records provided to the utilization review entity by the enrollee's healthcare provider, any relevant records provided to the utilization review entity by a facility, and any medical literature provided to the utilization review entity by the healthcare provider.

33-66-8.

If a utilization review entity requires prior authorization of a healthcare service, the utilization review entity shall notify the enrollee and the enrollee's healthcare provider of its prior authorization or adverse determination within two business days of obtaining all necessary information to make such authorization or adverse determination. For purposes of this Code section, 'necessary information' includes the results of any face-to-face clinical evaluation or second opinion that may be required.

33-66-9.

A utilization review entity shall render a prior authorization or adverse determination concerning urgent healthcare services and notify the enrollee and the enrollee's healthcare provider of that prior authorization or adverse determination no later than 24 hours after receiving all information needed to complete the review of the requested healthcare services.

33-66-10.

(a) A utilization review entity cannot require prior authorization for prehospital transportation or for the provision of emergency healthcare services.

(b) A utilization review entity shall allow an enrollee and the enrollee's healthcare provider a minimum of 24 hours following an emergency admission or provision of emergency healthcare services for the enrollee or healthcare provider to notify the utilization review entity of the admission or provision of healthcare services. If the admission or healthcare service occurs on a holiday or weekend, a utilization review entity cannot require notification until the next business day after the admission or provision of healthcare services.

(c) A utilization review entity shall cover emergency healthcare services necessary to screen and stabilize an enrollee. If a healthcare provider certifies in writing to a utilization review entity within 72 hours of an enrollee's admission that the enrollee's condition required emergency healthcare services, that certification will create a presumption that the emergency healthcare services were medically necessary healthcare services and such presumption may be rebutted only if the utilization review entity establishes, with clear and convincing evidence, that the emergency healthcare services were not medically necessary.

(d) The medical necessity or appropriateness of emergency healthcare services cannot be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency healthcare services provided by

nonparticipating providers cannot be greater than restrictions that apply when those services are provided by participating providers.

(e) If an enrollee receives an emergency healthcare service that requires immediate post-evaluation or post-stabilization services, a utilization review entity shall make an authorization determination within 60 minutes of receiving the request; if the authorization determination is not made within 60 minutes, such services shall be deemed approved.

33-66-11.

The utilization review entity shall not revoke, limit, condition, or restrict a prior authorization if healthcare services are provided within 45 working days from the date the healthcare provider received the prior authorization.

33-66-12.

Except as provided in Code Section 33-66-11, a prior authorization shall be valid for one year from the date the healthcare provider received the prior authorization and the authorization period shall be effective regardless of any changes in dosage for a prescription drug prescribed by the healthcare provider.

33-66-13.

If a utilization review entity requires a prior authorization for a healthcare 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 shall not require the enrollee to obtain a prior authorization again for such healthcare service.

33-66-14.

Prior authorization of a covered service shall be a guarantee of payment to the provider unless there is a billing error, fraud, or material misrepresentation.

33-66-15.

(a) Upon receipt of information documenting a prior authorization from the enrollee or from the enrollee's healthcare provider, a utilization review entity for at least the initial 60 days of an enrollee's new coverage shall honor a prior authorization granted to an enrollee from a previous utilization review entity even if approval criteria or products of a healthcare plan have changed or such enrollee is covered under a new healthcare plan, so long as the former criteria, products, or plans are not binding upon a new insurer.

(b) During the time period described in subsection (a) of this Code section, 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 healthcare service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of such change for the remainder of the enrollee's plan year so long as such enrollee remains covered by the same insurer.

(d) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee in accordance with Code section.

33-66-16.

No later than January 1, 2022, the payor shall accept and respond to prior authorization requests under the pharmacy benefit through a secure electronic transmission using the National Council for Prescription Drug Program's SCRIPT Standard ePA transactions, Version 2013101 in effect on the effective date of this chapter. Facsimile, propriety payor portals, electronic forms, or any other technology not directly integrated with a physician's electronic health record or electronic prescribing system shall not be considered a secure electronic transmission.

33-66-17.

Any failure by a utilization review entity to comply with the deadlines or other requirements specified in this chapter shall result in the automatic authorization of any healthcare services subject to pending review by such utilization review entity if such noncompliance is related to such services."

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.