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

AS PASSED SENATE

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 additional 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 provide for an effective date and applicability; 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 revising Chapter 46, relating to certification of private review agents, as follows:

″ARTICLE 1

33-46-1.

This chapter shall be construed liberally to promote consumer protection.

33-46-2.

This chapter applies to:

(1) Private review agents;

(2) All health insurers and stand-alone dental plans that provide accident and sickness insurance products whether on an individual, group, or blanket basis as provided in this title;

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

(4) All pharmacy benefits managers;

(5) All contracts entered into or renewed by the Department of Community Health with a contracted entity to provide healthcare coverage or services pursuant to the state health benefit plan;

(6) All contracts entered into or renewed by the Department of Community Health and care management organizations to provide or arrange for healthcare coverage or services on a prepaid, capitated basis to members; and

(7) All other entities and contracts as described and applicable herein.

~~33-46-1.~~ 33-46-3.

(a) The purpose of this chapter is to promote the delivery of quality ~~health care~~ healthcare in Georgia. Furthermore, it is to foster the delivery of such care in a cost-effective manner through greater coordination between ~~health care~~ healthcare providers, claims administrators, ~~payors,~~ insurers, employers, patients, and private review agents; to improve

communication and knowledge of ~~health care~~ healthcare benefits among all parties; to protect patients, claims administrators, ~~payors,~~ insurers, private review agents, employers, and ~~health care~~ healthcare providers by ensuring that utilization review activities are based upon accepted standards of treatment and patient care; to ensure that such treatment is accessible and done in a timely and effective manner; and to ensure that private review agents maintain confidentiality of information obtained in the course of utilization review.

(b) In order to carry out the intent and purposes of this chapter, it is declared to be the policy of this chapter to protect Georgia residents by imposing minimum standards on private review agents who engage in utilization review with respect to ~~health care~~ healthcare services provided in Georgia, such standards to include regulations concerning certification of private review agents, disclosure of utilization review standards and appeal procedures, minimum qualifications for utilization review personnel, minimum standards governing accessibility of utilization review, and such other standards, requirements, and rules or regulations promulgated by the Commissioner which are not inconsistent with the foregoing. Notwithstanding the foregoing, it is neither the policy nor the intent of the General Assembly to regulate the terms of self-insured employee welfare benefit plans as defined in Section 31(I) of the Employee Retirement Income Security Act of 1974, as amended, and therefore any regulations promulgated pursuant to this chapter shall relate only to persons subject to this chapter.

~~33-46-2.~~ 33-46-4.

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 a covered person 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) 'Care management organization' means an entity that is organized for the purpose of providing or arranging healthcare, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title and which has entered into a contract with the Department of Community Health to provide or arrange for healthcare services on a prepaid, capitated basis to members.

~~(1)~~(4) 'Certificate' means a certificate of registration granted by the Commissioner to a private review agent.

~~(2)~~(5) 'Claim administrator' means any entity that reviews and determines whether to pay claims to enrollees of ~~health care~~ healthcare providers on behalf of the ~~health benefit~~ healthcare plan. Such payment determinations are made on the basis of contract provisions including medical necessity and other factors. Claim administrators may be ~~payors~~ insurers or their designated review organization, self-insured employers, management firms, third-party administrators, or other private contractors.

(6) '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.

~~(3) "Commissioner" means the Commissioner of Insurance.~~

(7) 'Covered person' means an individual, including, but not limited to, any subscriber, enrollee, member, beneficiary, participant, or his or her dependent, eligible to receive

healthcare benefits by a health insurer pursuant to a healthcare plan or other health insurance coverage.

(8) 'Emergency healthcare services' means healthcare services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

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

(B) Serious impairment to bodily functions; or

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

~~(4) 'Enrollee' means the individual who has elected to contract for or participate in a health benefit plan for himself or himself and his eligible dependents.~~

(9) '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.

~~(5) 'Health benefit plan' means a plan of benefits that defines the coverage provisions for health care for enrollees offered or provided by any organization, public or private.~~

~~(6)~~(10) '~~Health care~~ Healthcare advisor' means a ~~health care~~ healthcare provider licensed in a state representing the claim administrator or private review agent who provides advice on issues of medical necessity or other patient care issues.

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

(12) 'Healthcare plan' means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, qualified higher deductible health plan, stand-alone

dental plan, health maintenance organization or other managed care subscriber contract, the state health benefit plan, or any plan entered into by a care management organization as permitted by the Department of Community Health for the delivery of healthcare services.

~~(7)~~(13) '~~Health care~~ Healthcare provider' means any person, corporation, facility, or institution licensed by this state or any other state to provide or otherwise lawfully providing ~~health care~~ healthcare services, including but not limited to a doctor of medicine, doctor of osteopathy, hospital or other ~~health care~~ healthcare facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, occupational therapist, professional counselor, pharmacist, chiropractor, marriage and family therapist, or social worker.

(14) '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.

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

(16) 'Medical necessity' or 'medically necessary' 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 or other healthcare practice;

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

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

(D) Not primarily custodial care, unless custodial care is a covered service or benefit under the covered person's healthcare plan.

(17) 'Member' means a Medicaid or Peachcare for Kids recipient who is currently enrolled in a care management organization plan.

~~(8) 'Payor' means any insurer, as defined in this title, or any preferred provider organization, health maintenance organization, self-insurance plan, or other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health care benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract of accident and sickness insurance as defined in Code Section 33-7-2.~~

(18) '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.

(19) '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 or concurrent with the rendering of such services. Such term shall include any health insurer's or utilization review entity's requirement that a covered person or healthcare provider notify the health insurer or utilization review entity prior to providing a healthcare service.

~~(9)~~(20) 'Private review agent' means any person or entity which performs utilization review for:

(A) An employer with employees who are treated by a ~~health care~~ healthcare provider in this state;

(B) ~~A payor~~ An insurer; or

(C) A claim administrator.

~~(10) 'Reasonable target review period' means the assignment of a proposed number of days for review for the proposed health care services based upon reasonable length of stay standards such as the Professional Activities Study of the Commission on the Professional and Hospital Activities or other Georgia state-specific length of stay data.~~

(21) 'State health benefit plan' means the health insurance plan or plans established pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 and Article 1 of Chapter 18 of Title 45 for state and public employees, dependents, and retirees.

(22) '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 covered person's medical condition:

(A) Could seriously jeopardize the life or health of the covered person or the ability of such person to regain maximum function; or

(B) Could subject the covered person 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.

~~(11)~~(23) 'Utilization review' means a system for reviewing the appropriate and efficient allocation or charges of hospital, outpatient, medical, or other ~~health care~~ healthcare services given or proposed to be given to a patient or group of patients for the purpose of advising the claim administrator who determines whether such services or the charges

therefor should be covered, provided, or reimbursed by ~~a payor~~ an insurer according to the benefits plan. Utilization review shall not include the review or adjustment of claims or the payment of benefits arising under liability, workers' compensation, or malpractice insurance policies as defined in Code Section 33-7-3.

(24) 'Utilization review entity' means an individual, insurer, or other 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; or

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

~~(12)~~(25) 'Utilization review plan' means a reasonable description of the standards, criteria, policies, procedures, reasonable target review periods, and reconsideration and appeal mechanisms governing utilization review activities performed by a private review agent.

~~33-46-3.~~ 33-46-5.

(a) A private review agent may not conduct utilization review of ~~health care~~ healthcare provided in this state unless the Commissioner has granted the private review agent a certificate pursuant to this chapter. No individual conducting utilization review shall require certification if such utilization review is performed within the scope of such person's employment with an entity already certified pursuant to this Code section.

(b) The Commissioner shall issue a certificate to an applicant that has met all the requirements of this chapter and all applicable regulations of the Commissioner.

(c) A certificate issued under this chapter is not transferable without the prior approval of the Commissioner.

~~33-46-4.~~ 33-46-6.

As a condition of certification or renewal thereof, a private review agent shall be required to maintain compliance with the following:

(1) Where not otherwise addressed in this chapter or department regulations, ~~The~~ the medical protocols including reconsideration and appeal processes as well as other relevant medical issues used in the private review program shall be established with input from ~~health care~~ healthcare providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency and documentation of such protocols shall be made available upon request of ~~health care~~ healthcare providers; or, where not so addressed, protocols, including reconsideration and appeal processes as well as other relevant ~~health care~~ healthcare issues used in the private review program, shall be established based on input from persons who are licensed in the appropriate ~~health care~~ healthcare provider's specialty recognized by a licensure agency of such a ~~health care~~ healthcare provider;

(2) All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating ~~health care~~ healthcare provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented;

~~(3) In the absence of any contractual agreement between the health care provider and the payor, the responsibility for obtaining precertification as well as concurrent review required by the payor shall be the responsibility of the enrollee;~~

~~(4)~~(3) In cases where a private review agent is responsible for utilization review for ~~a~~ ~~payor~~ an insurer or claim administrator, the utilization review agent should respond promptly and efficiently in accordance with this chapter to all requests including concurrent review in a timely method, and a method for an expedited authorization process shall be available in the interest of efficient patient care;

~~(5) In any instances where the utilization review agent is questioning the medical necessity or appropriateness of care, the attending health care provider shall be able to~~

~~discuss the plan of treatment with an identified health care provider trained in a related specialty and no adverse determination shall be made by the utilization review agent until an effort has been made to discuss the patient's care with the patient's attending provider during normal working hours. In the event of an adverse determination, notice to the provider and patient will specify the reasons for the review determination;~~

~~(6) To the extent that utilization review programs are administered according to recognized standards and procedures, efficiently with minimal disruption to the provision of medical care, additional payment to providers should not be necessary;~~

~~(7)~~(4) A private review agent shall assign a reasonable target review period in accordance with this chapter for each admission promptly upon notification by the ~~health care~~ healthcare provider. Once a target length of stay has been agreed upon with the ~~health care~~ healthcare provider, the utilization review agent will not attempt to contact the ~~health care~~ healthcare provider or patient for further information until the end of that target review period except for discharge planning purposes or in response to a contact by a patient or ~~health care~~ healthcare provider. The provider or the ~~health care~~ healthcare facility will be responsible for alerting the utilization review agent in the event of a change in proposed treatment. At the end of the target period, the private review agent will review the care for a continued stay;

~~(8)~~(5) A private review agent shall not enter into any incentive payment provision contained in a contract or agreement with ~~a payor~~ an insurer which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings; and

~~(9)~~(6) Any ~~health care~~ healthcare provider may designate one or more individuals to be contacted by the private review agent for information or data. In the event of any such designation, the private review agent shall not contact other employees or personnel of the ~~health care~~ healthcare provider except with prior consent to the ~~health care~~ healthcare

provider. An alternate will be available during normal business hours if the designated individual is absent or unavailable.

~~33-46-5.~~ 33-46-7.

(a) An applicant for a certificate shall submit an application on a form prescribed by the Commissioner and pay an application fee and a certificate fee as provided in Code Section 33-8-1. The application shall be signed and verified by the applicant.

(b) In conjunction with the application, the private review agent shall submit such information that the Commissioner requires, including but not limited to:

(1) A utilization review plan;

(2) The type and qualifications of the personnel either employed or under contract to perform the utilization review; and

(3) A copy of the materials designed to inform applicable patients and ~~health care~~ healthcare providers of the requirements of the utilization review plan.

The information provided must demonstrate to the satisfaction of the Commissioner that the private review agent will comply with the requirements of this chapter.

~~33-46-6.~~ 33-46-8.

(a) A certificate shall expire on the second anniversary of its effective date unless the certificate is renewed for a two-year term as provided in this Code section.

(b) Before the certificate expires but no sooner than 90 days prior to such expiration, a certificate may be renewed for an additional two-year term if the applicant:

(1) Otherwise is entitled to the certificate;

(2) Pays to the Commissioner the renewal fee as provided in Code Section 33-8-1;

(3) Submits to the Commissioner:

(A) A renewal application on the form that the Commissioner requires; and

(B) Satisfactory evidence of compliance with any requirements established by the Commissioner for certificate renewal; and

(4)(A) Establishes and maintains a complaint system which has been approved by the Commissioner and which provides reasonable procedures for the resolution of written complaints initiated by ~~enrollees~~ covered persons or ~~health care~~ healthcare providers concerning utilization review;

(B) Maintains records of such written complaints for five years from the time the complaints are filed and submits to the Commissioner a summary report at such times and in such format as the Commissioner may require; and

(C) Permits the Commissioner to examine the complaints at any time.

~~33-46-7.~~ 33-46-9.

Private review agents shall be subject to the jurisdiction of the Commissioner in all matters regulated by this chapter and the Commissioner shall have such powers and authority with regard to private review agents as provided in Code Sections 33-2-9 through 33-2-28 with regard to insurers.

~~33-46-8.~~ 33-46-10.

Private review agents shall be subject to the provisions of Chapter 39 of this title.

~~33-46-9~~. 33-46-11.

The Commissioner shall periodically, not less than once a year, provide a list of private review agents issued certificates and the renewal date for those certificates to all hospitals and to any other individual or organization requesting such list.

~~33-46-10.~~ 33-46-12.

The Commissioner shall establish such reporting requirements upon private review agents as are necessary to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable rules and regulations.

~~33-46-11.~~ 33-46-13.

The Commissioner shall adopt rules and regulations to implement the provisions of this chapter.

~~33-46-12.~~ 33-46-14.

No certificate is required for utilization review by any Georgia licensed pharmacist or pharmacy while engaged in the practice of pharmacy, including but not limited to review of the dispensing of drugs, participation in drug utilization review, and monitoring patient drug therapy.

~~33-46-13.~~ 33-46-15.

(a) This chapter shall not apply to any contract with the federal government for utilization and review of patients eligible for hospital services under Title XVIII or XIX of the Social Security Act.

(b) This chapter shall not apply to any private review agent when such private review agent is working under contract, or an extension or renewal thereof, with a licensed insurer operating under an agreement, providing administrative services pursuant to the provisions of subsection (b) of Code Section 33-20-17 to a ~~health care~~ healthcare benefit plan negotiated through collective bargaining as that term is defined in the federal National Labor Relations Act, as amended, if the original agreement was executed and in effect prior to January 1, 1990.

(c) This chapter shall not apply to audits of the medical record for the purposes of verifying that ~~health care~~ healthcare services were ordered and delivered.

~~33-46-14.~~ 33-46-16.

The Commissioner shall issue an annual report to the Governor and the General Assembly concerning the conduct of utilization review in this state. Such report shall include a description of utilization review programs and the services they provide, an analysis of complaints filed against private review agents by patients or providers, and an evaluation of the impact of utilization review programs on patient access to care. The Commissioner shall not be required to distribute copies of the annual report to ~~the members~~ legislators ~~of~~ in the General Assembly but shall notify ~~the members~~ such legislators of the availability of the report in the manner which he or she deems to be most effective and efficient.

ARTICLE 2

33-46-20.

(a) An insurer shall make any current prior authorization requirements and restrictions readily accessible on its website to healthcare providers. Clinical criteria on which an adverse determination is based shall be provided to the healthcare provider at the time of the notification.

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

(c) An insurer 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 or other provider speciality;

(2) Medication or diagnostic tests and procedures;

(3) Indication offered;

(4) Approved or denied on initial request;

(5) Reason for denial;

(6) Whether appealed;

(7) Whether approved or denied on appeal; and

(8) Time between submission and response.

33-46-21.

An insurer shall ensure that all adverse determinations are made by a physician, dentist, pharmacist, or other appropriately credentialed healthcare provider who shall possess a current and valid nonrestricted license or maintain other appropriate legal authorization to provide the healthcare services reviewed and who shall:

(1) Practice in the same specialty as the physician or other healthcare provider who typically manages the condition or disease or regularly provides the healthcare service involved in the request; or

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

33-46-22.

If a utilization review entity questions the medical necessity of a healthcare service, such entity shall notify the covered person's physician or other healthcare provider familiar with the case that medical necessity is being questioned. At least 72 hours before the final decision is made with regard to the medical necessity of such healthcare service, the covered person's physician or other healthcare provider shall have the opportunity to discuss such necessity on the telephone or through synchronous digital text or voice

messaging or similar technology with the physician or other healthcare provider who will be responsible for making the final decision with regard to the medical necessity of the healthcare service in question.

33-46-23.

A utilization review entity shall ensure that all appeals are reviewed by a physician, dentist, pharmacist, or other appropriately credentialed healthcare provider who shall possess a current and valid nonrestricted license or maintain other appropriate legal authorization to provide the healthcare services reviewed and who shall:

(1) Practice in the same specialty as the physician or other healthcare provider who typically manages the condition or disease or regularly provides the healthcare service involved in the request;

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

(3) 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;

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

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

33-46-24.

If a utilization review entity requires prior authorization of a healthcare service, the utilization review entity shall notify the covered person and such person's healthcare provider of its prior authorization or adverse determination within seven calendar 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.

33-46-25.

A utilization review entity shall render a prior authorization or adverse determination concerning urgent healthcare services and notify the covered person and such person's healthcare provider of that prior authorization or adverse determination no later than 72 hours after receiving all information needed to complete the review of the requested healthcare services.

33-46-26.

An insurer cannot require prior authorization for emergency prehospital ambulance transportation or for the provision of emergency healthcare services.

33-46-27.

If initial healthcare services are performed within 45 business days of approval of prior authorization, the insurer shall not revoke, limit, condition, or restrict such authorization, unless such authorization is for a Schedule II controlled substance.

33-46-28.

A covered person's physician or dentist may change the dosage of a prescription drug for such covered person and such change shall not affect a utilization review entity's decision.

33-46-29.

Prior authorization shall not be required for unanticipated covered healthcare services which are incidental to the primary covered healthcare services and determined by the covered person's physician or dentist to be medically necessary.

33-46-30.

If an insurer 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 six months during which time the insurer shall not require the covered person to obtain a prior authorization again for such healthcare service.

33-46-31.

Prior authorization of a covered healthcare service shall be a guarantee of payment to the provider if such services are performed unless there is a billing error, fraud, material misrepresentation, or loss of coverage.

33-46-32.

(a) Upon receipt of information documenting a prior authorization from the covered person or from such person's healthcare provider, a utilization review entity for at least the initial 30 days of such person's new coverage shall honor a prior authorization for a covered healthcare service granted to him or her from a previous utilization review entity even if approval criteria or products of a healthcare plan have changed or such person 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 a covered person who received prior authorization before the effective date of such change for the remainder of the covered person's plan year so long as such covered person remains covered by the same insurer.

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

33-46-33.

Each 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 healthcare services under review by such utilization review entity if such noncompliance is related to such services.

33-46-34.

With regard to the provision of healthcare services, each contract entered into or renewed by a managed care organization, each contract entered into or renewed by the Department of Community Health with a care management organization, and each contract entered into by such board with a contracted entity pursuant to the state health benefit plan shall comply with this chapter.

33-46-35.

The Commissioner shall not have the authority to approve, disapprove, or modify any plan offered by a care management organization or any contract between a care management organization and the Department of Community Health. Compliance with this chapter by care management organizations shall be enforced by the Department of Community Health.

33-46-36.

The Commissioner shall not have the authority to approve, disapprove, or modify the state health benefit plan or the contracts entered into by the Department of Community Health with a contracted entity to provide healthcare coverage or services pursuant to the state health benefit plan. Compliance with this chapter regarding the state health benefit plan shall be enforced by the Department of Community Health.

33-46-37.

Nothing in this chapter shall be construed as reducing the authority of the commissioner of community health."

SECTION 3.

This Act shall become effective on January 1, 2022, and shall apply to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after such date.

SECTION 4.

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