HOUSE BILL No. 1091

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-1-37.7.

Synopsis: Prior authorization. Requires, on or after January 1, 2026, health plans (plan) to allow health professionals who have at least an 85% approval rate of prior authorization requests through a plan to receive a one year exemption from the plan's prior authorization requirements. Provides that health professionals have a right to an appeal of a prior authorization denial or rescission. Provides that the appeal is to be conducted by a health professional of the same or similar specialty as the health professional who has or is being considered for an exemption.

Effective: July 1, 2024.

Pressel

January 8, 2024, read first time and referred to Committee on Insurance.

Introduced

Second Regular Session of the 123rd General Assembly (2024)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2023 Regular Session of the General Assembly.

HOUSE BILL No. 1091

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-37.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 37.7. Prior Authorization Exemption

Sec. 1. (a) This chapter does not:

(1) apply to prior authorization that is delegated by a health plan to a risk-bearing organization;

(2) require a health plan to perform prior authorization that has otherwise been delegated to a risk-bearing organization; or

(3) apply to vision only and dental only health plans and coverage.

(b) This chapter applies to the following:

(1) A pharmacy benefit manager under contract with a health plan to administer prior authorization for prescription drugs.

(2) All product types offered by the health plan that are regulated by the department, but including Medicaid

managed care plans only to the extent permissible under federal law.

Sec. 2. As used in this chapter, "health care entity" means a:

(1) hospital under IC 16-21;

(2) health facility under IC 16-28; and

(3) psychiatric facility under IC 12-25.

Sec. 3. (a) As used in this chapter, "health care service" means a health care procedure, treatment, or service that is either:

(1) provided at a health care entity licensed in Indiana; or

(2) provided or ordered by a health professional.

(b) The term includes the provision of pharmaceutical products or services, or durable medical equipment.

(c) The term does not include:

(1) specialty drugs;

(2) experimental, investigational, or unproven drugs or products under the applicable enrollee's coverage; or

(3) prescription drugs not approved by the federal Food and Drug Administration.

Sec. 4. As used in this chapter, "health plan" has the meaning set forth in IC 27-1-37.3-5.

Sec. 5. As used in this chapter, "health professional" means a physician licensed under IC 25-22.5.

Sec. 6. (a) As used in this chapter, "prior authorization" means the process by which utilization review determines the medical necessity or medical appropriateness of otherwise covered health care services before or concurrent with the rendering of those health care services.

(b) The term includes a health plan requirement that an enrollee or health professional notify the health plan before providing a health care service, including preauthorization, precertification, and prior approval of the health care service.

(c) The term does not include utilization review that is used and submitted by health care entities to track the ongoing appropriateness of care and confirm payment to the facilities from health plans.

Sec. 7. (a) As used in this chapter, "risk-bearing organization" means an entity that:

(1) is:

(A) a professional medical corporation, or other form of corporation controlled by health professionals;

(B) a medical partnership;

(C) a medical foundation exempt from licensure; or

(D) another lawfully organized group of health professionals that delivers, furnishes, or otherwise arranges for or provides health care services; and

(2) does all of the following:

(A) Contracts directly with a health plan or arranges for health care services for the health plan's enrollees.

(B) Receives compensation for those health care services on any capitated or fixed periodic payment basis.

(C) Is responsible for the processing and payment of claims made by health professionals for health care services rendered by those health professionals on behalf of a health plan that are covered under the capitation or fixed periodic payment made by the health plan to the risk-bearing organization.

(b) The term does not include:

(1) an individual or a health plan; or

(2) a provider organization that provides a health plan that files with the department consolidated financial statements that include the provider organization.

Sec. 8. (a) On or after January 1, 2026, a health plan shall not require a contracted health professional to complete or obtain a prior authorization for any covered health care services or treatments if, in the most recent completed one (1) year contracted period, the health plan approved not less than eighty-five percent (85%) of the prior authorization requests submitted by the health professional for the class of health care services or treatments subject to prior authorization for enrollees of the health plan.

(b) A health professional shall have a total contracting history of at least thirty-six (36) months with the health plan to be considered eligible for an exemption under subsection (a). The thirty-six (36) months do not need to be continuous.

(c) A health professional's exemption under subsection (a) shall apply to all health care services, items, and supplies, including drugs, that are covered by the health plan contract and are within the contracted health professional's medical licensure, board certification, specialty, or scope of practice.

(d) A health plan shall provide an electronic prior authorization process that a health professional shall agree to use in order to be considered for an exemption under subsection (a). However, a health plan may waive this requirement based on the health professional's access to requisite technologies and infrastructure, including broadband Internet.

Sec. 9. (a) A health plan shall evaluate whether a contracted health professional without an exemption from prior authorization requirements qualifies for an exemption under section 8 of this chapter once every twelve (12) months or upon the request of the health professional, but not more than once every twelve (12) months.

(b) A health plan may evaluate whether a contracted health professional continues to qualify for an exemption from prior authorization requirements under subsection (a) not more than once every twelve (12) months.

(c) This section does not require a health plan to evaluate an existing exemption period or prevent the establishment of a longer exemption period.

(d) A contracted health professional is not required to request an exemption from prior authorization requirements to qualify for the exemption.

(e) A health plan shall provide a health professional who receives an exemption with a notice that includes a statement that the health professional qualifies for the exemption and a statement of the duration of the exemption.

Sec. 10. (a) Upon a health professional's request, the health plan shall provide a health professional who is denied an exemption from the preauthorization requirements with:

(1) the facts and information that support the denial, including statistics and data for the relevant prior authorization request evaluation period; and

(2) detailed information sufficient to demonstrate that the health professional does not meet the criteria for an exemption under section 8 of this chapter.

(b) A health professional's exemption from prior authorization requirements shall remain in effect until the:

(1) thirtieth calendar day after the date the health plan notifies the health professional of the health plan's determination to rescind the exemption; or

(2) fifth business day after the date the independent review affirms the health plan's determination to rescind the exemption, if the health professional appeals the rescission determination.

Sec. 11. (a) A health plan shall only rescind a prior authorization exemption at the end of the twelve (12) month period and if the health plan meets all of the following requirements:

(1) For exemptions under section 8 of this chapter, makes a

determination that the health professional would not have met the eighty-five percent (85%) approval criteria based on a retrospective review of a sample of a minimum of thirty (30), but not more than fifty (50), claims for covered health care services for which the exemption applies for the previous twelve (12) months. However, if the health plan makes a determination that the health professional would have met the eighty-five percent (85%) approval criteria based on a retrospective review of a sample of thirty (30) claims for covered health care services for which the exemption applies for the previous twelve (12) months, the health plan need not review more than thirty (30) claims.

(2) Complies with other applicable requirements specified in this section, including:

(A) notifies the health professional at least thirty (30) calendar days before the proposed rescission of the exemption is to take effect; and

(B) provides the notice required under clause (A) with both of the following included:

(i) The information and data relied on to make the determination.

(ii) A plain language explanation of how the health professional may appeal and seek an independent review of the determination under this section.

(b) A determination to rescind or deny a prior authorization exemption shall be made by a health professional licensed in Indiana, who has the same or similar specialty as the health professional who has or is being considered for an exemption, and who has experience in providing the type of health care services for which the exemption applies.

(c) If a health plan does not finalize a rescission determination as specified in this section, the health professional is considered to have met the criteria under section 8 of this chapter to continue to qualify for the exemption.

(d) A health professional:

(1) may appeal the decision to deny or rescind a prior authorization exemption; and

(2) has a right to have the appeal conducted by a health professional licensed in Indiana who has the same or similar specialty as the health professional who has or is being considered for an exemption, and who was not directly involved in making the initial denial or rescission of the

exemption.

(e) The appeal described in subsection (d) may be conducted by a health plan's contracted specialist reviewer, provided the reviewer is a health professional of the same or similar specialty as the health professional seeking appeal.

(f) A health professional may request that the reviewing health professional conducting the appeal described in subsection (d) consider a random sample of claims submitted to the health plan by the health professional during the relevant evaluation period as part of the review.

(g) Within thirty (30) days of receipt of the appeal described in subsection (d), the health plan shall reconsider the denial or rescission of the prior authorization exemption and provide a written response to the health professional with the appeal determination and the basis for the determination, including pertinent facts and information relied upon in reaching the determination.

(h) A health plan shall:

(1) be bound by the determination made under this section; and

(2) not retroactively deny or modify a covered health care service on the basis of a rescission of a prior authorization exemption, even if the health plan's determination to rescind the exemption is affirmed pursuant to this section.

(i) Following a final determination or review affirming the rescission or denial of a prior authorization exemption, a health professional is eligible for consideration of an exemption after a twelve (12) month period.

Sec. 12. A health plan shall not deny or reduce payment for a covered health care service exempted from a prior authorization requirement under section 8 of this chapter, including a covered health care service performed or supervised by another health professional when the performing or supervising health professional or other health professional who ordered the health care service received a prior authorization exemption, unless the performing or supervising health professional or other health professional did either of the following:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to a health plan with the specific intent to deceive and obtain an unlawful payment from the health plan.

(2) Failed to substantially perform the health care service.

Sec. 13. Nothing in this chapter shall be interpreted to prevent a health plan from taking action, including rescinding a prior authorization exemption granted under section 8 of this chapter at any time, against a contracted health professional who has been found, through an investigation by the health plan, to have committed fraud or to have a pattern of waste or abuse in violation of the health plan's contract.

Sec. 14. A grievance or appeal submitted by or on behalf of an enrollee regarding a delay, denial, or modification of health care services shall be reviewed by a physician and surgeon of the same or similar specialty as the physician and surgeon requesting prior authorization for those health care services.

Sec. 15. A health plan's policies and procedures shall include a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify health care services, items, and supplies, including drugs, that are regularly approved.