

MEDICAL TREATMENT AUTHORIZATION AMENDMENTS

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Evan J. Vickers

House Sponsor: Suzanne Harrison

LONG TITLE

General Description:

This bill enacts provisions relating to preauthorization of health care.

Highlighted Provisions:

This bill:

- ▶ defines terms;
- ▶ requires an insurer to post certain information regarding requirements for the authorization for health care;
- ▶ prohibits an insurer from denying certain requests for authorization of health care;
- ▶ requires an insurer to respond to a request for authorization for health care within a certain time period;
- ▶ creates requirements when an insurer changes certain policies in the middle of a plan year; and
- ▶ creates a reporting requirement.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

31A-2-201.2, as last amended by Laws of Utah 2018, Chapter 319

31A-4-116, as last amended by Laws of Utah 2002, Chapter 308

31A-22-613.5, as last amended by Laws of Utah 2017, Chapters 241 and 292

30 ENACTS:

31 **31A-22-650**, Utah Code Annotated 1953

32

33 *Be it enacted by the Legislature of the state of Utah:*

34 Section 1. Section **31A-2-201.2** is amended to read:

35 **31A-2-201.2. Evaluation of health insurance market.**

36 (1) Each year the commissioner shall:

37 (a) conduct an evaluation of the state's health insurance market;

38 (b) report the findings of the evaluation to the Health and Human Services Interim

39 Committee before December 1 of each year; and

40 (c) publish the findings of the evaluation on the department website.

41 (2) The evaluation required by this section shall:

42 (a) analyze the effectiveness of the insurance regulations and statutes in promoting a

43 healthy, competitive health insurance market that meets the needs of the state, and includes an

44 analysis of:

45 (i) the availability and marketing of individual and group products;

46 (ii) rate changes;

47 (iii) coverage and demographic changes;

48 (iv) benefit trends;

49 (v) market share changes; and

50 (vi) accessibility;

51 (b) assess complaint ratios and trends within the health insurance market, which

52 assessment shall include complaint data from the Office of Consumer Health Assistance within

53 the department;

54 (c) contain recommendations for action to improve the overall effectiveness of the

55 health insurance market, administrative rules, and statutes; ~~and~~

56 (d) include claims loss ratio data for each health insurance company doing business in

57 the state[-]; and

58 (e) include information, for each health insurance company doing business in the state,
59 regarding:

60 (i) preauthorization determinations; and

61 (ii) adverse benefit determinations.

62 (3) When preparing the evaluation and report required by this section, the
63 commissioner may seek the input of insurers, employers, insured persons, providers, and others
64 with an interest in the health insurance market.

65 (4) The commissioner may adopt administrative rules for the purpose of collecting the
66 data required by this section, taking into account the business confidentiality of the insurers.

67 (5) Records submitted to the commissioner under this section shall be maintained by
68 the commissioner as protected records under Title 63G, Chapter 2, Government Records
69 Access and Management Act.

70 Section 2. Section **31A-4-116** is amended to read:

71 **31A-4-116. Adverse benefit determination procedures.**

72 (1) If an insurer has established a complaint resolution body or grievance appeal board,
73 the body or board shall include at least one consumer representative.

74 (2) Adverse benefit determination procedures for health insurance policies and health
75 maintenance organization contracts shall be established in accordance [~~Section~~] Sections
76 31A-22-629 and 31A-22-650.

77 Section 3. Section **31A-22-613.5** is amended to read:

78 **31A-22-613.5. Price and value comparisons of health insurance.**

79 (1) (a) This section applies to all health benefit plans.

80 (b) Subsection (2) applies to:

81 (i) all health benefit plans; and

82 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

83 (2) The commissioner shall promote informed consumer behavior and responsible
84 health benefit plans by requiring an insurer issuing a health benefit plan to provide to all
85 enrollees, before enrollment in the health benefit plan, written disclosure of:

- 86 (a) restrictions or limitations on prescription drugs and biologics, including:
- 87 (i) the use of a formulary;
- 88 (ii) co-payments and deductibles for prescription drugs; and
- 89 (iii) requirements for generic substitution;
- 90 (b) coverage limits under the plan;
- 91 (c) any limitation or exclusion of coverage, including:
- 92 (i) a limitation or exclusion for a secondary medical condition related to a limitation or
- 93 exclusion from coverage; and
- 94 (ii) easily understood examples of a limitation or exclusion of coverage for a secondary
- 95 medical condition;
- 96 (d) (i) (A) each drug, device, and covered service that is subject to a preauthorization
- 97 requirement as defined in Section 31A-22-650; or
- 98 (B) if listing each device or covered service in accordance with Subsection (2)(d)(i)(A)
- 99 is too numerous to list separately, all devices or covered services in a particular category where
- 100 all devices or covered services have the same preauthorization requirement;
- 101 (ii) each requirement for authorization as defined in Section 31A-22-650 for:
- 102 (A) each drug, device, or covered service described in Subsection (2)(d)(i)(A); and
- 103 (B) each category of devices or covered services described in Subsection (2)(d)(i)(B);
- 104 and
- 105 (iii) sufficient information to allow a network provider or enrollee to submit all of the
- 106 information to the insurer necessary to meet each requirement for authorization described in
- 107 Subsection (2)(d)(ii);
- 108 ~~(d)~~ (e) whether the insurer permits an exchange of the adoption indemnity benefit in
- 109 Section 31A-22-610.1 for infertility treatments, in accordance with Subsection
- 110 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits; and
- 111 ~~(e)~~ (f) whether the insurer provides coverage for telehealth services in accordance
- 112 with Section 26-18-13.5 and terms associated with that coverage.
- 113 (3) An insurer shall provide the disclosure required by Subsection (2)~~(a)(i)~~ in writing

114 to the commissioner:

- 115 (a) upon commencement of operations in the state; and
- 116 (b) anytime the insurer amends any of the following described in Subsection (2):
 - 117 (i) treatment policies;
 - 118 (ii) practice standards;
 - 119 (iii) restrictions;
 - 120 (iv) coverage limits of the insurer's health benefit plan or health insurance policy; or
 - 121 (v) limitations or exclusions of coverage including a limitation or exclusion for a
 - 122 secondary medical condition related to a limitation or exclusion of the insurer's health
 - 123 insurance plan.

124 (4) (a) An insurer shall provide the enrollee with notice of an increase in costs for
125 prescription drug coverage due to a change in benefit design under Subsection (2)(a):

- 126 (i) either:
 - 127 (A) in writing; or
 - 128 (B) on the insurer's website; and
- 129 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
- 130 soon as reasonably possible.

131 (b) If under Subsection (2)(a) a formulary is used, the insurer shall make available to
132 prospective enrollees and maintain evidence of the fact of the disclosure of:

- 133 (i) the drugs included;
- 134 (ii) the patented drugs not included;
- 135 (iii) any conditions that exist as a precedent to coverage; and
- 136 (iv) any exclusion from coverage for secondary medical conditions that may result
- 137 from the use of an excluded drug.

138 (c) [(†)] The commissioner shall develop examples of limitations or exclusions of a
139 secondary medical condition that an insurer may use under Subsection (2)(c).

140 [(†)] (5) Examples of a limitation or exclusion of coverage provided under [Subsection
141 (2)(c)] this section or otherwise are for illustrative purposes only, and the failure of a particular

142 fact situation to fall within the description of an example does not, by itself, support a finding
143 of coverage.

144 (6) An insurer shall:

145 (a) post the information described in Subsection (2)(d) on the insurer's website and
146 provider portal;

147 (b) if requested by an enrollee, provide the enrollee with the information required by
148 this section by mail or email; and

149 (c) if requested by a network provider for a specific drug, device, or covered service,
150 provide the network provider with the information described in Subsection (2)(d) for the drug,
151 device, or covered service by mail or email.

152 Section 4. Section **31A-22-650** is enacted to read:

153 **31A-22-650. Health care preauthorization requirements.**

154 (1) As used in this section:

155 (a) "Adverse preauthorization determination" means a determination by an insurer that
156 health care does not meet the preauthorization requirement for the health care.

157 (b) "Authorization" means a determination by an insurer that for health care with a
158 preauthorization requirement:

159 (i) the proposed drug, device, or covered service meets all requirements, restrictions,
160 limitations, and clinical criteria for authorization established by the insurer;

161 (ii) the drug, device, or covered service is covered by the enrollee's insurance policy;
162 and

163 (iii) the insurer will provide coverage for the drug, device, or covered service subject to
164 the provisions of the insurance policy, including any cost sharing responsibilities of the
165 enrollee.

166 (c) "Device" means a prescription device as defined in Section [58-17b-102](#).

167 (d) "Drug" means the same as that term is defined in Section [58-17b-102](#).

168 (e) "Insurer" means the same as that term is defined in Section [31A-22-634](#).

169 (f) "Preauthorization requirement" means a requirement by an insurer that an enrollee

170 obtain authorization for a drug, device, or service covered by the insurance policy, before
171 receiving the drug, device, or service.

172 (2) (a) An insurer may not modify an existing requirement for authorization unless, at
173 least 30 days before the day on which the modification takes effect, the insurer:

174 (i) posts a notice of the modification on the website described in Subsection
175 31A-22-613.5(6)(a); and

176 (ii) if requested by a network provider or the network provider's representative,
177 provides to the network provider by mail or email a written notice of modification to a
178 particular requirement for authorization described in the request from the network provider.

179 (b) Subsection (2)(a) does not apply if:

180 (i) complying with Subsection (2)(a) would create a danger to the enrollee's health or
181 safety; or

182 (ii) the modification is for a newly covered drug or device.

183 (c) An insurer may not revoke an authorization for a drug, device, or covered service if:

184 (i) the network provider submits a request for authorization for the drug, device, or
185 covered service to the insurer;

186 (ii) the insurer grants the authorization requested under Subsection (2)(c)(i);

187 (iii) the network provider renders the drug, device, or covered service to the enrollee in
188 accordance with the authorization and any terms and conditions of the network provider's
189 contract with the insurer;

190 (iv) on the day on which the network provider renders the drug, device, or covered
191 service to the enrollee:

192 (A) the enrollee is eligible for coverage under the enrollee's insurance policy; and

193 (B) the enrollee's condition or circumstances related to the enrollee's care have not
194 changed;

195 (v) the network provider submits an accurate claim that matches the information in the
196 request for authorization under Subsection (2)(c)(i); and

197 (vi) the authorization was not based on fraudulent or materially incorrect information

198 from the network provider.

199 (3) (a) An insurer that receives a request for authorization shall treat the request as a
200 pre-service claim as defined in 29 C.F.R. Sec. 2560.503-1 and process the request in
201 accordance with:

202 (i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an
203 individual or group health insurance policy;

204 (ii) Subsection 31A-4-116(2); and

205 (iii) Section 31A-22-629.

206 (b) If a network provider submits a claim to an insurer that includes an unintentional
207 error that results in a denial of the claim, the insurer shall permit the network provider with an
208 opportunity to resubmit the claim with corrected information within a reasonable amount of
209 time.

210 (c) Except as provided in Subsection (3)(d), the appeal of an adverse preauthorization
211 determination regarding clinical or medical necessity as requested by a physician may only be
212 reviewed by a physician who is currently licensed as a physician and surgeon in a state, district,
213 or territory of the United States.

214 (d) The appeal of an adverse determination requested by a physician regarding clinical
215 or medical necessity of a drug, may only be reviewed by an individual who is currently licensed
216 in a state, district, or territory of the United States as:

217 (i) a physician and surgeon; or

218 (ii) a pharmacist.

219 (e) An insurer shall ensure that an adverse preauthorization determination regarding
220 clinical or medical necessity is made by an individual who:

221 (i) has knowledge of the medical condition or disease of the enrollee for whom the
222 authorization is requested; or

223 (ii) consults with a specialist who has knowledge of the medical condition or disease of
224 the enrollee for whom the authorization is requested regarding the request before making the
225 determination.

226 (f) An insurer shall specify how long an authorization is valid.
227 (4) (a) An insurer that removes a drug from the insurer's formulary shall:
228 (i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to
229 request an exemption from the change to the formulary for the purpose of providing the patient
230 with continuity of care; and
231 (ii) have a process to review and make a decision regarding an exemption requested
232 under Subsection (4)(a)(i).
233 (b) If an insurer makes a change to the formulary for a drug in the middle of a plan
234 year, the insurer may not implement the changes for an enrollee that is on an active course of
235 treatment for the drug unless the insurer provides the enrollee with notice at least 30 days
236 before the day on which the change is implemented.
237 (5) Before April 1, 2021, and before April 1 of each year thereafter, an insurer with a
238 preauthorization requirement shall report to the department, for the previous calendar year, the
239 percentage of authorizations, not including a claim involving urgent care as defined in 29
240 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or
241 adverse preauthorization determination more than one week after the day on which the insurer
242 received the request for authorization.
243 (6) An insurer may not have a preauthorization requirement for emergency health care
244 as described in Section [31A-22-627](#).
245 Section 5. **Effective date.**
246 This bill takes effect on January 1, 2020.