Second Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 24-0202.01 Christy Chase x2008 **HOUSE BILL 24-1149**

HOUSE SPONSORSHIP

Bird and Frizell, Amabile, Armagost, Bacon, Boesenecker, Bottoms, Bradfield, Clifford, deGruy Kennedy, Duran, English, Froelich, Garcia, Hamrick, Hartsook, Hernandez, Jodeh, Kipp, Lieder, Lindstedt, Mabrey, McLachlan, Ortiz, Rutinel, Sirota, Snyder, Soper, Taggart, Titone, Valdez, Velasco, Weinberg, Willford, Wilson, Young

SENATE SPONSORSHIP

Roberts and Kirkmeyer, Ginal, Baisley, Bridges, Buckner, Coleman, Cutter, Gonzales, Hansen, Hinrichsen, Kolker, Liston, Marchman, Michaelson Jenet, Mullica, Pelton R., Rich, Van Winkle, Will, Winter F., Zenzinger

House Committees
Health & Human Services

Senate Committees

A BILL FOR AN ACT

CONCERNING MODIFICATIONS TO REQUIREMENTS FOR PRIOR AUTHORIZATION OF BENEFITS UNDER HEALTH BENEFIT PLANS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

With regard to prior authorization requirements imposed by carriers, private utilization review organizations (organizations), and pharmacy benefit managers (PBMs) for certain health-care services and prescription drug benefits covered under a health benefit plan, the bill requires carriers, organizations, and PBMs, as applicable, to adopt a program, in consultation with participating providers, to eliminate or

substantially modify prior authorization requirements in a manner that removes administrative burdens on qualified providers and their patients with regard to certain health-care services, prescription drugs, or related benefits based on specified criteria. Additionally, a carrier or organization is prohibited from denying a claim for a health-care procedure a provider provides, in addition or related to an approved surgical procedure, under specified circumstances or from denying an initially approved surgical procedure on the basis that the provider provided an additional or a related health-care procedure.

The bill extends the duration of an approved prior authorization for a health-care service or prescription drug benefit from 180 days to a calendar year.

Carriers are required to post, on their public-facing websites, specified information regarding:

- The number of prior authorization requests that are approved, denied, and appealed;
- The number of prior authorization exemptions or alternatives to prior authorization requirements provided pursuant to a program developed and offered by the carrier, an organization, or a PBM; and
- The prior authorization requirements as applied to prescription drug formularies for each health benefit plan the carrier or PBM offers.

The bill applies to conduct occurring on or after January 1, 2026.

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

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Timely access to necessary health care is of vital importance to Coloradans;

(b) The provider-patient relationship is paramount and should not be subject to intrusion by a third party;

(c) Coloradans and their health-care providers deserve easy access to information regarding health insurance benefits so that, together, they can determine the proper course of treatment;

(d) Utilization management processes, such as prior authorization,

delay care, which, according to thirty-four percent of physicians surveyed nationally, leads to serious adverse events for their patients, including hospitalization, permanent disability, or even death;

(e) These outcomes due to delays in timely accessing services and prescriptions are known to disproportionately impact historically marginalized populations, such as Black and Hispanic patients, furthering health disparities in the state;

(f) Surveys have found that over sixty percent of physicians also report that it is difficult to determine whether a prescription medication or medical service requires prior authorization, adding burdensome administrative steps for health-care providers and patients to understand requirements for accessing necessary medical services or prescriptions; and

(g) Health systems spend an average of twenty dollars, for a primary care visit, to two hundred fifteen dollars, for an inpatient surgical procedure, on administrative tasks to navigate insurer utilization management processes like processing prior authorization requests.

(2) Therefore, it is the intent of the general assembly, by establishing transparent prescription formularies and enabling access to prior authorization requirements at the point of care delivery; requiring posting of data on prior authorization practices; and requiring carriers, private utilization review organizations, and pharmacy benefit managers to adopt a program that streamlines the administrative process for qualifying health-care providers who satisfy certain objective criteria regarding quality and appropriateness of care and specialty area and experience, to:

(a) Ensure Coloradans have equitable access to medically

necessary care;

(b) Reduce administrative burdens and costs borne by health-care providers; and

(c) Reduce overall costs to the health-care system.

SECTION 2. In Colorado Revised Statutes, 10-16-112.5, **amend** (2)(a), (2)(c), (3)(c)(II), (4)(b), (5)(a), (6), and (7)(e); and **add** (4)(c), (4)(d), and (7)(g) as follows:

10-16-112.5. Prior authorization for health-care services - disclosures and notice - determination deadlines - criteria - limits and exceptions - definitions - rules - enforcement. (2) **Disclosure of requirements - notice of changes.** (a) (I) A carrier shall ~~make~~ POST current prior authorization requirements and restrictions, including written, clinical criteria, ~~readily accessible~~ on the carrier's PUBLIC-FACING website IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE FORMAT. The prior authorization requirements must be described in detail and in clear and easily understandable language.

(II) If a carrier contracts with a private utilization review organization to perform prior authorization for health-care services, the organization shall provide its prior authorization requirements and restrictions, as required by this subsection (2), to the carrier with ~~whom~~ WHICH the organization contracted, and that carrier shall post the organization's prior authorization requirements and restrictions on its PUBLIC-FACING website IN THE MANNER REQUIRED BY SUBSECTION (2)(a)(I) OF THIS SECTION.

~~(III) When posting prior authorization requirements and restrictions pursuant to this subsection (2)(a) or subsection (2)(b) of this section, a carrier is neither required to post nor prohibited from posting~~

~~the prior authorization requirements and restrictions on a public-facing portion of its website.~~

(c) (I) A carrier shall post, on a public-facing portion of its website, data regarding approvals and denials of prior authorization requests, including requests for drug benefits pursuant to section 10-16-124.5, in a readily accessible, STANDARDIZED, SEARCHABLE format and that include the following: ~~categories, in the aggregate:~~

(A) ~~Provider specialty~~ THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS RECEIVED IN THE IMMEDIATELY PRECEDING CALENDAR YEAR IN EACH OF THE FOLLOWING CATEGORIES OF SERVICES: MEDICAL PROCEDURES; DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES; PRESCRIPTION DRUGS; AND ALL OTHER CATEGORIES OF HEALTH-CARE SERVICES OR DRUG BENEFITS FOR WHICH A PRIOR AUTHORIZATION REQUEST WAS RECEIVED;

(B) ~~Medication or diagnostic test or procedure~~ THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE APPROVED IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION;

(C) ~~Reason for denial; and~~ THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS FOR WHICH AN ADVERSE DETERMINATION WAS ISSUED AND THE SERVICE WAS DENIED IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION; AND

(D) ~~Denials specified under subsection (2)(c)(I)(C) of this section that are overturned on appeal~~ IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION, THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE APPEALED AND WHETHER THE DETERMINATION WAS UPHELD OR REVERSED ON APPEAL.

(II) An organization OR PBM that provides prior authorization for a carrier shall provide the data specified in subsection (2)(c)(I) of this section to the carrier with ~~whom~~ WHICH the organization OR PBM contracted, and the carrier shall post the organization's OR PBM'S data on its PUBLIC-FACING website IN THE MANNER REQUIRED BY SUBSECTION (2)(c)(I) OF THIS SECTION.

(III) Carriers and organizations shall use the data specified in this subsection (2)(c) to refine and improve their utilization management programs. CARRIERS AND ORGANIZATIONS SHALL REVIEW THE LIST OF MEDICAL PROCEDURES, DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES, PRESCRIPTION DRUGS, AND OTHER HEALTH-CARE SERVICES FOR WHICH THE CARRIER OR ORGANIZATION REQUIRES PRIOR AUTHORIZATION AT LEAST ANNUALLY AND SHALL ELIMINATE THE PRIOR AUTHORIZATION REQUIREMENTS FOR THOSE PROCEDURES, DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES, PRESCRIPTION DRUGS, OR OTHER HEALTH-CARE SERVICES FOR WHICH PRIOR AUTHORIZATION REQUESTS ARE APPROVED WITH SUCH FREQUENCY AS TO DEMONSTRATE THAT THE PRIOR AUTHORIZATION REQUIREMENT NEITHER PROMOTES HEALTH-CARE QUALITY OR EQUITY NOR REDUCES HEALTH-CARE SPENDING TO A DEGREE SUFFICIENT TO JUSTIFY THE ADMINISTRATIVE COSTS TO THE CARRIER OR ORGANIZATION. EACH CARRIER AND ORGANIZATION SHALL ANNUALLY ATTEST THAT IT HAS COMPLETED THE REVIEW REQUIRED BY THIS SUBSECTION (2)(c)(III) AND HAS ELIMINATED PRIOR AUTHORIZATION REQUIREMENTS CONSISTENT WITH THE REQUIREMENTS OF THIS SUBSECTION (2)(c)(III).

(IV) A CARRIER SHALL POST, ON A PUBLIC-FACING PORTION OF ITS WEBSITE, IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE

FORMAT, DATA ON THE NUMBER OF EXEMPTIONS FROM PRIOR AUTHORIZATION REQUIREMENTS OR ALTERNATIVES TO PRIOR AUTHORIZATION REQUIREMENTS PROVIDED PURSUANT TO A PROGRAM ADOPTED BY THE CARRIER, ORGANIZATION, OR PBM PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION OR SECTION 10-16-124.5 (5.5), AS APPLICABLE. THE CARRIER SHALL INCLUDE THE FOLLOWING DATA:

(A) THE NUMBER OF PROVIDERS OFFERED AN EXEMPTION OR ALTERNATIVE PROGRAM, INCLUDING THEIR SPECIALTY AREAS;

(B) THE NUMBER AND CATEGORIZED TYPES OF EXEMPTIONS OR ALTERNATIVE PROGRAMS OFFERED TO PROVIDERS; AND

(C) THE PRESCRIPTION DRUG, DIAGNOSTIC TEST, PROCEDURE, OR OTHER HEALTH-CARE SERVICE FOR WHICH AN EXEMPTION OR ALTERNATIVE PROGRAM WAS OFFERED.

(V) THE COMMISSIONER SHALL ADOPT RULES TO IMPLEMENT SUBSECTIONS (2)(c)(I) AND (2)(c)(IV) OF THIS SECTION TO ENSURE THAT THE DATA FIELDS REQUIRED TO BE POSTED PURSUANT TO SUBSECTIONS (2)(c)(I) AND (2)(c)(IV) OF THIS SECTION ARE PRESENTED CONSISTENTLY BY CARRIERS.

(3) **Nonurgent and urgent health-care services - timely determination - notice of determination - deemed approved.** (c) (II) If the carrier or organization denies a prior authorization request based on a ground specified in section 10-16-113 (3)(a), the notification is subject to the requirements of section 10-16-113 (3)(a) and commissioner rules adopted pursuant to that section and must include information concerning whether the carrier or organization requires an alternative treatment, test, procedure, or medication AND WHAT ALTERNATIVE SERVICES OR MEDICATIONS WOULD BE APPROVED AS A COVERED BENEFIT UNDER THE

HEALTH BENEFIT PLAN. A CARRIER'S OR ORGANIZATION'S COMPLIANCE WITH THIS SUBSECTION (3)(c)(II) DOES NOT CONSTITUTE THE PRACTICE OF MEDICINE.

(4) **Criteria, limits, and exceptions.** (b) (I) Carriers and organizations shall consider limiting the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors and present opportunities for improvement in adherence to the carrier's or organization's prior authorization requirements.

(II) ~~(A)~~ NO LATER THAN JANUARY 1, 2026, a carrier or AN organization ~~may offer providers with a history of adherence to the carrier's or organization's prior authorization requirements at least one alternative to prior authorization, including an exemption from prior authorization requirements for a provider that has at least an eighty percent approval rate of prior authorization requests over the immediately preceding twelve months.~~ SHALL ADOPT A PROGRAM, DEVELOPED IN CONSULTATION WITH PROVIDERS PARTICIPATING WITH THE CARRIER, TO ELIMINATE OR SUBSTANTIALLY MODIFY PRIOR AUTHORIZATION REQUIREMENTS IN A MANNER THAT REMOVES THE ADMINISTRATIVE BURDEN FOR QUALIFIED PROVIDERS, AS DEFINED UNDER THE PROGRAM, AND THEIR PATIENTS FOR CERTAIN HEALTH-CARE SERVICES AND RELATED BENEFITS BASED ON ANY OF THE FOLLOWING:

(A) THE PERFORMANCE OF PROVIDERS WITH RESPECT TO ADHERENCE TO NATIONALLY RECOGNIZED, EVIDENCE-BASED MEDICAL GUIDELINES, APPROPRIATENESS, EFFICIENCY, AND OTHER QUALITY CRITERIA; AND

(B) PROVIDER SPECIALTY, EXPERIENCE, OR OTHER OBJECTIVE

FACTORS; EXCEPT THAT ELIGIBILITY FOR THE PROGRAM MUST NOT BE LIMITED BY PROVIDER SPECIALTY.

(III) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION:

(A) MUST NOT REQUIRE QUALIFIED PROVIDERS TO REQUEST PARTICIPATION IN THE PROGRAM; AND

(B) MAY INCLUDE LIMITING THE USE OF PRIOR AUTHORIZATION TO PROVIDERS WHOSE PRESCRIBING OR ORDERING PATTERNS DIFFER SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS AFTER ADJUSTING FOR PATIENT MIX AND OTHER RELEVANT FACTORS AND IN ORDER TO PRESENT THOSE PROVIDERS WITH OPPORTUNITIES FOR IMPROVEMENT IN ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS.

(IV) At least annually, a carrier or AN organization shall:

(A) Reexamine a provider's prescribing or ordering patterns; ~~and~~

(B) Reevaluate the provider's status for exemption from ~~or other alternative to~~ prior authorization requirements OR FOR INCLUSION IN THE PROGRAM DEVELOPED pursuant to ~~this~~ subsection (4)(b)(II) OF THIS SECTION; AND

~~(B)~~ (C) ~~The carrier or organization shall inform~~ NOTIFY the provider of the provider's STATUS FOR exemption ~~status and provide information on the data considered as part of its reexamination of the provider's prescribing or ordering patterns for the twelve-month period of review~~ OR INCLUSION IN THE PROGRAM.

(V) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION MUST INCLUDE PROCEDURES FOR A PROVIDER TO REQUEST:

(A) AN EXPEDITED, INFORMAL RESOLUTION OF A CARRIER'S OR AN ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM; AND

(B) IF THE MATTER IS NOT RESOLVED THROUGH INFORMAL RESOLUTION, A BINDING, INDEPENDENT EXTERNAL REVIEW OF THE CARRIER'S OR ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM USING A REVIEWER APPOINTED BY THE COMMISSIONER FROM THE LIST OF ARBITRATORS APPROVED PURSUANT TO SECTION 10-16-704 (15)(b). THE PROVIDER AND THE CARRIER OR ORGANIZATION SHALL SUBMIT WRITTEN MATERIALS TO THE REVIEWER WITHIN THIRTY DAYS AFTER THE REVIEWER'S APPOINTMENT, AND THE REVIEWER SHALL ISSUE A DETERMINATION WITHIN FORTY-FIVE DAYS AFTER SUCH APPOINTMENT.

(c) IF A CARRIER AND A PROVIDER ARE ENGAGED IN A VALUE-BASED REIMBURSEMENT ARRANGEMENT FOR PARTICULAR HEALTH-CARE SERVICES OR PARTICULAR POLICYHOLDERS, THE CARRIER SHALL NOT IMPOSE ANY PRIOR AUTHORIZATION REQUIREMENTS FOR ANY PARTICULAR HEALTH-CARE SERVICE THAT IS INCLUDED IN THE VALUE-BASED REIMBURSEMENT ARRANGEMENT.

(d) (I) WHEN A CARRIER OR AN ORGANIZATION APPROVES A PRIOR AUTHORIZATION REQUEST FOR A SURGICAL PROCEDURE FOR WHICH PRIOR AUTHORIZATION IS REQUIRED, THE CARRIER OR ORGANIZATION SHALL NOT DENY A CLAIM FOR AN ADDITIONAL OR A RELATED HEALTH-CARE PROCEDURE IDENTIFIED DURING THE AUTHORIZED SURGICAL PROCEDURE IF:

(A) THE PROVIDER, WHILE PROVIDING THE APPROVED SURGICAL PROCEDURE TO TREAT THE COVERED PERSON, DETERMINES, IN

ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE, THAT PROVIDING A RELATED HEALTH-CARE PROCEDURE, INSTEAD OF OR IN ADDITION TO THE APPROVED SURGICAL PROCEDURE, IS MEDICALLY NECESSARY AS PART OF THE TREATMENT OF THE COVERED PERSON AND THAT, IN THE PROVIDER'S CLINICAL JUDGMENT, TO INTERRUPT OR DELAY THE PROVISION OF CARE TO THE COVERED PERSON IN ORDER TO OBTAIN PRIOR AUTHORIZATION FOR THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE WOULD NOT BE MEDICALLY ADVISABLE;

(B) THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE IS A COVERED BENEFIT UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(C) THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE IS NOT EXPERIMENTAL OR INVESTIGATIONAL;

(D) AFTER COMPLETING THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE AND BEFORE SUBMITTING A CLAIM FOR PAYMENT, THE PROVIDER NOTIFIES THE CARRIER OR ORGANIZATION THAT THE PROVIDER PERFORMED THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE AND INCLUDES IN THE NOTICE THE INFORMATION REQUIRED UNDER THE CARRIER'S OR ORGANIZATION'S CURRENT PRIOR AUTHORIZATION REQUIREMENTS POSTED IN ACCORDANCE WITH SUBSECTION (2)(a)(I) OF THIS SECTION; AND

(E) THE PROVIDER IS COMPLIANT WITH THE CARRIER'S OR ORGANIZATION'S POST-SERVICE CLAIMS PROCESS, INCLUDING SUBMISSION OF THE CLAIM WITHIN THE CARRIER'S OR ORGANIZATION'S REQUIRED TIMELINE FOR CLAIMS SUBMISSIONS.

(II) WHEN A PROVIDER PROVIDES AN ADDITIONAL OR A RELATED HEALTH-CARE PROCEDURE AS DESCRIBED IN THIS SUBSECTION (4)(d), THE CARRIER OR ORGANIZATION SHALL NOT DENY THE CLAIM FOR THE INITIAL

SURGICAL PROCEDURE FOR WHICH THE CARRIER OR ORGANIZATION APPROVED A PRIOR AUTHORIZATION REQUEST ON THE BASIS THAT THE PROVIDER PROVIDED THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE.

(5) **Duration of approval.** (a) Upon approval by the carrier or organization, a prior authorization is valid for at least one ~~hundred eighty days~~ CALENDAR YEAR after the date of approval and continues for the duration of the authorized course of treatment. Except as provided in subsection (5)(b) of this section, once approved, a carrier or AN organization shall not retroactively deny the prior authorization request for a health-care service.

(6) **Rules - enforcement.** (a) The commissioner may adopt rules as necessary to implement this section.

(b) THE COMMISSIONER MAY ENFORCE THE REQUIREMENTS OF THIS SECTION AND IMPOSE A PENALTY OR OTHER REMEDY AGAINST A PERSON THAT VIOLATES THIS SECTION.

(7) **Definitions.** As used in this section:

(e) "Private utilization review organization" or "organization" ~~has the same meaning as set forth~~ MEANS A PRIVATE UTILIZATION REVIEW ORGANIZATION, AS DEFINED in section 10-16-112 (1)(a), THAT HAS A CONTRACT WITH AND PERFORMS PRIOR AUTHORIZATION ON BEHALF OF A CARRIER.

(g) "VALUE-BASED REIMBURSEMENT" MEANS REIMBURSEMENT THAT:

(I) TIES A PAYMENT FOR THE PROVISION OF HEALTH-CARE SERVICES TO THE QUALITY OF HEALTH CARE PROVIDED;

(II) REWARDS A PROVIDER FOR EFFICIENCY AND EFFECTIVENESS;

AND

(III) MAY IMPOSE A RISK-SHARING REQUIREMENT ON A PROVIDER FOR HEALTH-CARE SERVICES THAT DO NOT MEET THE CARRIER'S REQUIREMENTS FOR QUALITY, EFFECTIVENESS, AND EFFICIENCY.

SECTION 3. In Colorado Revised Statutes, 10-16-124.5, **amend** (3)(b) introductory portion, (5), and (6); **repeal** (4); and **add** (3.5), (5.5), (6.5), and (8)(c) as follows:

10-16-124.5. Prior authorization form - drug benefits - rules of commissioner - definitions - repeal. (3) (b) In developing the uniform prior authorization process, the commissioner shall take into consideration ~~the recommendations, if any, of the work group established pursuant to subsection (4) of this section and~~ the following:

(3.5) (a) ON AND AFTER JANUARY 1, 2026, A CARRIER SHALL POST ON THE CARRIER'S PUBLIC-FACING WEBSITE, IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE FORMAT, PRIOR AUTHORIZATION REQUIREMENTS AS APPLICABLE TO THE PRESCRIPTION DRUG FORMULARY FOR EACH HEALTH BENEFIT PLAN THE CARRIER OFFERS, INCLUDING THE FOLLOWING INFORMATION:

(I) THE HEALTH BENEFIT PLAN TO WHICH THE FORMULARY APPLIES;

(II) EACH PRESCRIPTION DRUG THAT IS COVERED UNDER THE HEALTH BENEFIT PLAN, INCLUDING BOTH GENERIC AND BRAND-NAME VERSIONS OF A PRESCRIPTION DRUG;

(III) ANY PRESCRIPTION DRUGS ON THE FORMULARY THAT ARE PREFERRED OVER OTHER PRESCRIPTION DRUGS OR ANY ALTERNATIVE PRESCRIPTION DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION;

(IV) ANY EXCLUSIONS FROM OR RESTRICTIONS ON COVERAGE,

INCLUDING:

(A) ANY TIERING STRUCTURE, INCLUDING COPAYMENT AND COINSURANCE REQUIREMENTS;

(B) PRIOR AUTHORIZATION, STEP THERAPY, AND OTHER UTILIZATION MANAGEMENT CONTROLS;

(C) QUANTITY LIMITS; AND

(D) WHETHER ACCESS IS DEPENDENT UPON THE LOCATION WHERE A PRESCRIPTION DRUG IS OBTAINED OR ADMINISTERED; AND

(V) THE APPEAL PROCESS FOR A DENIAL OF COVERAGE OR ADVERSE DETERMINATION FOR AN ITEM OR SERVICE FOR A PRESCRIPTION DRUG.

(b) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO IMPLEMENT THIS SUBSECTION (3.5).

(4) ~~(a) Within thirty days after May 15, 2013, the commissioner shall establish a work group comprised of representatives of:~~

~~(I) The department of regulatory agencies;~~

~~(II) Local and national carriers;~~

~~(III) Captive and noncaptive pharmacy benefit management firms;~~

~~(IV) Providers, including hospitals, physicians, advanced practice registered nurses with prescriptive authority, and pharmacists;~~

~~(V) Drug manufacturers;~~

~~(VI) Medical practice managers;~~

~~(VII) Consumers; and~~

~~(VIII) Other stakeholders deemed appropriate by the commissioner.~~

~~(b) The work group shall assist the commissioner in developing the prior authorization process and shall make recommendations to the~~

~~commissioner on the items set forth in paragraph (b) of subsection (3) of this section. The work group shall report its recommendations to the commissioner no later than six months after the commissioner appoints the work group members. Regardless of whether the work group submits recommendations to the commissioner, the commissioner shall not delay or extend the deadline for the adoption of rules creating the prior authorization process as specified in paragraph (a) of subsection (3) of this section.~~

(5) (a) Notwithstanding any other provision of law, ~~on and after January 1, 2015~~ AND EXCEPT AS PROVIDED IN SUBSECTIONS (5)(b), (5)(c), AND (5.5) OF THIS SECTION, every prescribing provider shall use the prior authorization process developed pursuant to subsection (3) of this section to request prior authorization for coverage of drug benefits, and every carrier and pharmacy benefit management firm shall use that process for prior authorization for drug benefits.

(b) (I) A CARRIER OR PBM THAT PROVIDES DRUG BENEFITS UNDER A HEALTH BENEFIT PLAN SHALL NOT IMPOSE PRIOR AUTHORIZATION REQUIREMENTS UNDER THE HEALTH BENEFIT PLAN FOR A DRUG THAT IS APPROVED BY THE FDA AND THAT IS A CHRONIC MAINTENANCE DRUG IF THE CARRIER OR PBM HAS PREVIOUSLY APPROVED A PRIOR AUTHORIZATION FOR THE COVERED PERSON FOR USE OF THE CHRONIC MAINTENANCE DRUG.

(II) AS USED IN THIS SUBSECTION (5)(b), "CHRONIC MAINTENANCE DRUG" HAS THE MEANING SET FORTH IN SECTION 12-280-103 (9.5).

(c) IF A CARRIER OR PBM AND A PROVIDER ARE ENGAGED IN A VALUE-BASED REIMBURSEMENT ARRANGEMENT FOR PARTICULAR PRESCRIPTION DRUGS OR PARTICULAR POLICYHOLDERS, THE CARRIER

SHALL NOT IMPOSE ANY PRIOR AUTHORIZATION REQUIREMENTS FOR ANY PARTICULAR PRESCRIPTION DRUG THAT IS INCLUDED IN THE VALUE-BASED REIMBURSEMENT ARRANGEMENT.

(5.5) (a) NO LATER THAN JANUARY 1, 2026, A CARRIER OR PBM SHALL ADOPT A PROGRAM, DEVELOPED IN CONSULTATION WITH PROVIDERS PARTICIPATING WITH THE CARRIER, TO ELIMINATE OR SUBSTANTIALLY MODIFY PRIOR AUTHORIZATION REQUIREMENTS IN A MANNER THAT REMOVES THE ADMINISTRATIVE BURDEN FOR QUALIFIED PROVIDERS, AS DEFINED UNDER THE PROGRAM, AND THEIR PATIENTS FOR CERTAIN PRESCRIPTION DRUGS AND RELATED DRUG BENEFITS BASED ON ANY OF THE FOLLOWING:

(I) THE PERFORMANCE OF PROVIDERS WITH RESPECT TO ADHERENCE TO NATIONALLY RECOGNIZED, EVIDENCE-BASED MEDICAL GUIDELINES, APPROPRIATENESS, EFFICIENCY, AND OTHER QUALITY CRITERIA; AND

(II) PROVIDER SPECIALTY, EXPERIENCE, OR OTHER OBJECTIVE FACTORS; EXCEPT THAT ELIGIBILITY FOR THE PROGRAM MUST NOT BE LIMITED BY PROVIDER SPECIALTY.

(b) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION:

(I) MUST NOT REQUIRE QUALIFIED PROVIDERS TO REQUEST PARTICIPATION IN THE PROGRAM; AND

(II) MAY INCLUDE LIMITING THE USE OF PRIOR AUTHORIZATION TO PROVIDERS WHOSE PRESCRIBING OR ORDERING PATTERNS DIFFER SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS AFTER ADJUSTING FOR PATIENT MIX AND OTHER RELEVANT FACTORS AND IN ORDER TO PRESENT THOSE PROVIDERS WITH OPPORTUNITIES FOR IMPROVEMENT IN

ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS.

(c) AT LEAST ANNUALLY, A CARRIER OR PBM SHALL:

(I) REEXAMINE A PROVIDER'S PRESCRIBING OR ORDERING PATTERNS;

(II) REEVALUATE THE PROVIDER'S STATUS FOR EXEMPTION FROM PRIOR AUTHORIZATION REQUIREMENTS OR FOR INCLUSION IN THE PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION; AND

(III) NOTIFY THE PROVIDER OF THE PROVIDER'S STATUS FOR EXEMPTION OR INCLUSION IN THE PROGRAM.

(d) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION MUST INCLUDE PROCEDURES FOR A PROVIDER TO REQUEST:

(A) AN EXPEDITED, INFORMAL RESOLUTION OF A CARRIER'S OR PBM'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM; AND

(B) IF THE MATTER IS NOT RESOLVED THROUGH INFORMAL RESOLUTION, A BINDING, INDEPENDENT EXTERNAL REVIEW OF THE CARRIER'S OR PBM'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM USING A REVIEWER APPOINTED BY THE COMMISSIONER FROM THE LIST OF ARBITRATORS APPROVED PURSUANT TO SECTION 10-16-704 (15)(b). THE PROVIDER AND THE CARRIER OR PBM SHALL SUBMIT WRITTEN MATERIALS TO THE REVIEWER WITHIN THIRTY DAYS AFTER THE REVIEWER'S APPOINTMENT, AND THE REVIEWER SHALL ISSUE A DETERMINATION WITHIN FORTY-FIVE DAYS AFTER SUCH APPOINTMENT.

(6) Upon approval by the carrier or pharmacy benefit management firm, a prior authorization is valid for at least one ~~hundred eighty days~~

CALENDAR YEAR after the date of approval. If, as a result of a change to the carrier's formulary, the drug for which the carrier or pharmacy benefit management firm has provided prior authorization is removed from the formulary or moved to a less preferred tier status, the change in the status of the previously approved drug does not affect a covered person who received prior authorization before the effective date of the change for the remainder of the covered person's plan year. Nothing in this subsection (6) limits the ability of a carrier or pharmacy benefit management firm, in accordance with the terms of the health benefit plan, to substitute a generic drug, with the prescribing provider's approval and patient's consent, for a previously approved brand-name drug.

(6.5) THE COMMISSIONER MAY ENFORCE THE REQUIREMENTS OF THIS SECTION AND IMPOSE A PENALTY OR OTHER REMEDY AGAINST A PERSON THAT VIOLATES THIS SECTION.

(8) As used in this section:

(c) "VALUE-BASED REIMBURSEMENT" MEANS REIMBURSEMENT THAT:

(I) TIES A PAYMENT FOR THE PROVISION OF HEALTH-CARE SERVICES TO THE QUALITY OF HEALTH CARE PROVIDED;

(II) REWARDS A PROVIDER FOR EFFICIENCY AND EFFECTIVENESS; AND

(III) MAY IMPOSE A RISK-SHARING REQUIREMENT ON A PROVIDER FOR HEALTH-CARE SERVICES THAT DO NOT MEET THE CARRIER'S REQUIREMENTS FOR QUALITY, EFFECTIVENESS, AND EFFICIENCY.

SECTION 4. Act subject to petition - effective date - applicability. (1) This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the

general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2024 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) This act applies to conduct occurring on or after January 1, 2026.