ENGROSSED ORIGINAL

A BILL

25-124

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To prescribe the manner in which a utilization review entity shall make publicly available information on prior authorization requirements and restrictions, to set notice requirements for prior authorization determinations, to prescribe the minimum length that a prior authorization approval shall be considered valid, to set the qualifications for personnel authorized to make adverse determinations and appeals, to permit enrollees to appeal an adverse determination and to set deadlines for submissions of appeals, to prescribe a utilization review entity's obligations to review requests for prior authorization for non-urgent, urgent, and emergency health care services, to permit utilization review entities to require prior authorization only based on a determination of medical necessity for different care and to prohibit a utilization review entity from requiring prior authorization for a treatment solely based on cost, to prohibit a utilization review entity from revoking, limiting, conditioning, or restricting approval if care was provided within 45 days of approval, to require that a utilization review entity honor an approval granted by a previous utilization review entity for at least the first 60 days of coverage, to clarify that health care services are deemed authorized if a utilization review entity fails to comply with title I of this act, and to require a utilization review entity make certain statistics available to the public; to amend the Uniform Health Insurance Claims Forms Act of 1995 to require all utilization review entities accept and respond to prior authorization requests using the NCPDP SCRIPT Standard ePA transaction by January 1, 2024; and to amend the Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998 to require that employers provide notice to employees of treatments, including particular services or medications, not included in a negotiated health benefit plan but that are included in the standard health benefit plan or formulary offered by the health insurer.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Prior Authorization Reform Amendment Act of 2023".

TITLE I. PRIOR AUTHORIZATION.

Sec. 101. Definitions.

For purposes of this title, the term:

(1) "Adverse determination" means a decision by a utilization review entity that the health care services furnished or proposed to be furnished to an enrollee is denied, reduced, or terminated as being not medically necessary or experimental or investigational.

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

(3) "Emergency health care service" means a health care service that is provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to place the patient's health in serious jeopardy or to cause serious impairment to bodily function or serious dysfunction of any bodily organ or part.

(4) "Enrollee" means an individual eligible to receive health care benefits by a health insurer pursuant to a health plan or other health insurance coverage.

(5) "Long-term services and supports" means institutional and home and community-based services provided under the District's Medicaid State Plan or any

corresponding waiver thereof, including long-term nursing facility care, intermediate care facility services, State Plan home health and personal care aide services, services covered under the Program for All-Inclusive Care for the Elderly, and home and community-based services authorized under section 1915(c) and (i) of the Social Security Act, approved August 13, 1981 (95 Stat. 809; 42 U.S.C. 1396n(c) and (i)), and section 1115 of the Social Security Act, approved July 25, 1962 (76 Stat. 192; 42 U.S.C. § 1315).

(6) "Medication assisted treatment" means the use of medications to provide a comprehensive approach to the treatment of substance use disorders.

(7) "Prior authorization" means the process by which a utilization review entity determines the medical necessity or medical appropriateness of covered health care services prior to the rendering of such services, including any notification that an enrollee or health care provider is required to provide to the health insurer or utilization review entity prior to the provision of a health care service.

(8) "Representative" means the enrollee's legally authorized representative.

(9) "Urgent health care service" means:

(A) A health care service that, in the opinion of a physician with knowledge of the enrollee's medical condition, if not receiving an expedited approval:

(i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization review; or

(B) Medication assisted treatment.

(10) "Utilization review entity" means an individual or entity that performs prior authorization review for:

(A) A health insurer as that term is defined in section 5040 of the Healthy DC Act of 2008, effective August 16, 2008 (D.C. Law 17-219; D.C. Official Code § 4-631);

(B) A preferred provider organization or health maintenance organization as those terms are described in section 2105(2) and (3) of the District of Columbia Comprehensive Merit Personnel Act of 1978, effective October 1, 1987 (D.C. Law 8-190; D.C. Official Code § 1-621.05(2) and (3));

(C) A health benefits plan provided through Medicaid;

(D) A health benefits plan provided through DC HealthCare Alliance; or

(E) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a person treated by a health care provider in the District under a policy, plan, or contract that is regulated by the District.

Sec. 102. Prior authorization requirements and restrictions.

(a)(1) A utilization review entity may only require prior authorization for a covered health care service based on a determination of medical necessity for different care or that the proposed care is experimental or investigational in nature.

(2) A utilization review entity may not require prior authorization:

(A) Based solely on the cost of a covered health care service; provided, that:

(i) A health benefits plan provided through Medicaid may require prior authorization based on a preferred drug list; and

(ii) A health benefits plan provided through DC HealthCare Alliance may require prior authorization based on a preferred drug list;

(B) For the provision of medication assisted treatment; or

(C) For pre-hospital transportation or for the provision of emergency health care services, including emergency health care services to screen and stabilize an enrollee.

(b) A utilization review entity shall:

(1) Post its current prior authorization requirements and restrictions, including formulary ("prior authorization requirements"), on its website, in a manner accessible to the general public without the need to create an account;

(2) Email or provide a hard copy of the prior authorization requirements to an enrollee, representative, or health care provider upon request by telephone or in writing; and

(3) Provide information on its prior authorization requirements, upon request, to an enrollee, representative, or health care provider over the telephone.

(c) Prior authorization requirements shall:

(1) Be described in detail and easily understandable language;

(2) Include any written clinical criteria;

(3) Include a comprehensive listing of all drugs that require prior authorization; and

(4) Include the process for submitting, and standards for considering, including evidence-based guidelines, where possible, requests for:

(A) Prior authorization approval;

(B) Reauthorization of a prior grant of approval; and

(C) An appeal of an adverse determination.

(d) If a utilization review entity intends to amend or replace its prior authorization requirements, any changes to the requirements shall not be effective until the utilization review entity's website has been updated to reflect the new requirements.

Sec. 103. Prior authorization in non-urgent, urgent, and emergency circumstances.

(a) If a utilization review entity requires prior authorization of a health care service, the utilization review entity shall, after receiving all required information to make its decision, make

an approval or adverse determination and notify the enrollee, representative, and the enrollee's health care provider of its decision within:

(1) For an urgent health care service, 24 hours;

(2) For long-term services and supports, 30 days; provided, that the enrollee has been determined to be otherwise eligible for such benefits under Medicaid; and

(3) For all other health care services, 3 business days of receiving the request via electronic portal or 5 business days of receiving the request via mail, telephone, or facsimile.

(b) A health care service described under subsection (a) of this section shall be deemed approved if the utilization review entity does not provide notice within the time frames provided by that subsection.

(c) The notice required under subsection (a) of this section shall include:

(1) The qualifications of the individual making the determination, including:

(A) States in which the individual is licensed;

(B) Status of their medical licenses; and

(C) Their Medical specialty; and

(2) For an adverse determination, an explanation of:

(A) The utilization review entity's reasons for making an adverse determination based on its prior authorization requirements;

(B) The enrollee's right to appeal;

(C) The process to file an appeal; and

(D) All information necessary to support a successful appeal of the adverse determination.

(d)(1) If the utilization review entity determines that required information is missing, the utilization review entity shall promptly notify the enrollee, representative, and the enrollee's health care provider of its need for additional information.

(2) Prior to issuing an adverse determination, the utilization review entity shall notify the enrollee's health care provider that the medical necessity of the health care service is being questioned and give the responsible physician an opportunity to provide additional information or clarification on the medical necessity of the health care service.

(e)(1) A utilization review entity shall provide an enrollee, representative, and the enrollee's health care provider a minimum of 24 hours (excluding weekends and legal public holidays) following an emergency hospital admission or the provision of emergency health care services to notify the utilization review entity of the admission or provision of emergency health care services.

(2) If a health care provider certifies in writing to a utilization review entity within 72 hours of an enrollee's receipt of emergency health care services that the enrollee's condition required emergency health care services, the emergency health care services shall be presumed to have been medically necessary and may be rebutted only if the utilization review entity

establishes through clear and convincing evidence that the emergency health care services were not medically necessary.

(3) A utilization review entity may not consider whether the emergency health care services were provided by a nonparticipating provider when determining the medical necessity or appropriateness of those services and may not impose greater restrictions on the coverage of emergency health care services provided by nonparticipating providers than those that apply to the same services provided by participating providers.

(f) For purposes of this section, the term "required information" includes the results of any face-to-face clinical evaluation or second opinion that may be required under the utilization review entity's prior authorization requirements.

Sec. 104. Length of prior authorization.

(a) Except as otherwise provided in subsection (b) of this section, approval shall be valid for at least one year from the date the enrollee receives notice of the approval and shall remain valid regardless of any changes in dosage for a prescription drug prescribed by the health care provider; provided, that the utilization review entity may rescind the approval for dosages exceeding limitations set by federal or District laws or regulations.

(b)(1) Approval for a course of treatment, as that term is defined at 2 CFR 422.112(b)(8)(ii)(A), or for a health care service to treat a chronic condition shall remain valid for as long as medically reasonable and necessary to avoid disruptions in care, in accordance

with applicable coverage criteria, the enrollee's medical history, and the treating provider's recommendation.

(2) The Department of Health Care Finance may require annual reauthorization for long-term services and supports.

(c) A utilization review entity may not revoke, limit, condition, or restrict approval if care is provided within 45 business days from the date the enrollee receives notice of the approval; provided, that approval may be revoked or otherwise restricted in cases of fraud.

Sec. 105. Appeals.

(a) A utilization review entity shall provide an enrollee with at least 15 calendar days from the date the enrollee receives notice of an adverse determination to appeal the decision via the utilization review entity's website, facsimile, or mail; provided, that an appeal submitted by mail shall be considered timely if postmarked within 15 calendar days of the enrollee receiving notice.

(b) In reviewing an appeal, the utilization review entity shall consider all known clinical aspects of the health care service under review, including a review of all pertinent medical records, other relevant records, and any medical literature provided by the enrollee, representative, or the enrollee's health care provider.

(c) The enrollee, representative, and the enrollee's health care provider shall be notified within 24 hours of the utilization review entity making a decision on the appeal, which shall include the following information:

(1) The qualifications of the physician reviewing the appeal including:

(A) States in which the physician is licensed;

(B) Status of their medical licenses;

(C) Their medical specialty; and

(D) Years of practice in that specialty; and

(2) The grounds for the physician's decision under the utilization review entity's prior authorization requirements.

Sec. 106. Review personnel qualifications.

(a)(1) A utilization review entity shall ensure that an adverse determination is made by a physician who:

(A) Possesses a current and valid non-restricted license to practice medicine in the District, Maryland, or Virginia; and

(B) Is of the same or similar specialty as a physician who typically manages the medical condition or disease or provides the health care service involved in the request; provided, that a physician making an adverse determination for pediatric care shall have a pediatric specialty.

(2) The reviewing physician shall:

(A) Be under the clinical direction of one of the utilization review entity's medical directors licensed in the District who is responsible for providing health care services to enrollees in the District.; and

(B) Not receive any financial incentive based on the number of adverse determinations made; provided, that the utilization review entity may establish medically appropriate performance standards.

(b)(1) A utilization entity shall ensure that all appeals are reviewed by a physician who:

(A) Possesses a current and valid non-restricted license to practice medicine in the District, Maryland, or Virginia;

(B) Is of the same or similar specialty as a physician who typically manages the medical condition or disease or provides the health care service involved in the request; provided, that the physician reviewing an appeal for pediatric care shall have a pediatric specialty and practiced that specialty for at least 5 years; and

(C) Is knowledgeable of, and have experience providing, the health care service on appeal.

(2) A physician reviewing an appeal shall not:

(A) Receive any financial incentive based on the number of adverse determinations made or upheld on appeal; provided, that the utilization review entity may establish medically appropriate performance standards; and

(B) Have been directly involved in making the adverse determination and is not a subordinate of the physician who made the adverse determination.

Sec. 107. Continuity of care for enrollees.

(a)(1) A utilization review entity shall honor an approval granted by a previous utilization review entity for at least the initial 60 days of an enrollee's coverage under a new health benefits plan; provided, that the utilization review entity may condition honoring the approval on receipt of information documenting the approval.

(2) During the 60-day period described in subsection (a) of this section, a utilization review entity may perform its own prior authorization review; provided, that if the utilization review entity issues an adverse determination following review, the adverse determination may not take effect before the end of the 60-day period described in subsection (a) of this section.

(b) If a health insurer changes coverage of, or approval criteria for, a health care service for which an enrollee previously received approval, the change in coverage or approval criteria shall not apply to an enrollee who received approval before the effective date of the change for the duration of the approval.

(c) A utilization review entity shall honor a prior approval to an enrollee who changes health benefit plans offered by the same health insurer.

Sec. 108. Failure to comply and penalties.

(a) Any failure by a utilization review entity to comply with the requirements specified in this title shall result in the health care service in question being deemed approved.

(b) An action by a utilization review entity that establishes a pattern or practice of repeated violations of this title, as determined by the Commissioner of the Department of Insurance and Securities Regulation, shall constitute a violation as provided in the Insurance Trade and Economic Development Amendment Act of 2000, effective April 3, 2001 (D.C. Law 13-265; D.C. Official Code § 31-2231.01 *et seq.*).

Sec. 109. Data transparency.

(a)(1) Beginning January 1, 2025, a utilization review entity shall make available on its website, or by phone upon request, to an enrollee, representative, and health care provider, the information required by paragraph (2) of this subsection regarding the enrollee's active prior authorization requests made to that utilization review entity in at least the preceding 5 years; provided that, this paragraph shall not apply to a prior authorization request made before the effective date of this title.

(2) The following information shall be made available to an enrollee:

(A) A copy of all information or materials submitted by the enrollee's health care provider in support of a request for approval or reauthorization, or an appeal from an adverse determination, which shall clearly show the date the information or materials were submitted, the health care service prescribed by the health care provider, and the reason, if any, provided by the health care provider in requesting the health care service; and

(B) A copy of all notices of determination provided to the enrollee issued pursuant to section 103 of this title.

(b) Beginning January 1, 2025, a utilization review entity shall make publicly available on its website in a readily accessible format statistics regarding approvals, adverse determinations, and appeals, including information on the:

(1) Specialties of physicians reviewing prior authorization requests or appeals;

(2) Types of medication, tests, procedures, or treatment in which approval was being sought;

(3) Medical indication offered in each request;

(4) Reasons for an adverse determination;

(5) Number of appeals taken;

(6) Number of appeals approved or denied;

(7) Time between submission of a request and the utilization review entity's determination; and

(8) Time between submission of an appeal and the utilization review entity's determination.

(c) This section shall not apply to information pertaining to long-term services and supports.

Sec. 110. Rulemaking.

The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), may issue rules to implement the provisions of this title.

TITLE II. AMENDMENTS.

Sec. 201. Section 2 of the Uniform Health Insurance Claim Forms Act of 1995, effective February 27, 1996 (D.C. Law 11-89; D.C. Code § 31-3201), is amended by adding a new subsection (c) to read as follows:

"(c)(1) No later than January 1, 2024, a utilization review entity shall accept and respond to prior authorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions, which shall not include facsimile, propriety payer portals, electronic forms, or any other technology not directly integrated with a physician's electronic health record or electronic prescribing system.

"(2) For the purposes of this subsection, the term:

"(A) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs SCRIPT Standard Version 2013101, or the most recent standard adopted by the United States Department of Health and Human Services.

"(B) "Prior authorization" shall have the same meaning as provided in section 101(7) of the Prior Authorization Reform Amendment Act of 2023, as approved by the Committee on Health on September 26, 2023 (Committee print of Bill 25-124).

"(C) "Utilization review entity" shall have the same meaning as provided in section 101(10) of the Prior Authorization Reform Amendment Act of 2023, as approved by the Committee on Health on September 26, 2023 (Committee print of Bill 25-124).".

Sec. 202. The Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998, effective April 13, 1999 (D.C. Law 12-209; D.C. Official Code § 31-3301.01 *et seq.*), is amended by adding a new section 313e to read as follows:

"Sec. 313e. Negotiated health benefit plans.

"(a) When a negotiated health benefit plan differs in coverage of health services from the standard health benefit plan or formulary offered by the health insurer, the employer shall provide notice to all employees, regardless of whether they are enrolled in the negotiated health benefit plan, of any treatments, including particular services or medications, covered under the

standard health benefit plan or formulary but are not covered under the negotiated health benefit plan or formulary offered to employees.

"(b) Notice under subsection (a) of this section shall be provided to employees:

"(1) At least 30 days prior to the conclusion of any open enrollment period; and

"(2) Within 30 days after the employer and health insurer finalize the terms of coverage under a negotiated health benefit plan.

"(c) For the purposes of this section, the term "negotiated health benefit plan" means a health benefit plan that an employer negotiates with a health insurer to provide to its employees which may otherwise differ from the standard health benefit plan offered by the health insurer.".

TITLE III. APPLICABILITY; FISCAL IMPACT STATEMENT; EFFECTIVE DATE.

Sec. 301. Applicability.

(a) Sections 101(5), (10)(C), and (D), 102(a)(2)(A)(i) and (ii), 103(a)(2), 104(b)(2), and 109(c) shall apply upon the date of inclusion of its fiscal effect in an approved budget and financial plan.

(b) The Chief Financial Officer shall certify the date of the inclusion of the fiscal effect in an approved budget and financial plan, and provide notice to the Budget Director of the Council of the certification.

(c)(1) The Budget Director shall cause the notice of the certification to be published in the District of Columbia Register.

(2) The date of publication of the notice of the certification shall not affect the applicability of this act.

Sec. 302. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 303. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.