HOUSE BILL No. 1143

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8-19; IC 27-1-37.5; IC 27-8-28-6.

Synopsis: Prior authorization for health care services. Specifies requirements for prior authorization of health plan coverage and claim payment, including provisions requiring electronic transmission of prior authorization requests and responses or, in certain circumstances, use of a standard prior authorization form established by the department of insurance.

Effective: July 1, 2018.

Schaibley

January 8, 2018, read first time and referred to Committee on Insurance.

Introduced

Second Regular Session of the 120th General Assembly (2018)

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 2017 Regular Session of the General Assembly.

HOUSE BILL No. 1143

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 5-10-8-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: **Sec. 19. A self-insurance program established under section 7(b) of this chapter to provide health care coverage shall comply with the prior authorization requirements that apply to a health plan under IC 27-1-37.5.**

SECTION 2. IC 27-1-37.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]:

Chapter 37.5. Health Care Service Prior Authorization

Sec. 1. (a) Except as provided in sections 10 and 11 of this chapter, this chapter applies beginning September 1, 2018.

(b) This chapter does not apply to a step therapy protocol exception procedure under IC 27-8-5-30 or IC 27-13-7-23.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 3. As used in this chapter, "CPT code" refers to the medical

billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.

Sec. 4. (a) As used in this chapter, "health care service" means a health care related service or product rendered or sold by a health care provider within the scope of the health care provider's license or legal authorization, including hospital, medical, surgical, mental health, and substance abuse services or products.

(b) The term does not include the following:

(1) Dental services.

(2) Vision services.

(3) Long term rehabilitation treatment.

(4) Pharmaceutical services or products.

Sec. 5. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.

Sec. 6. As used in this chapter, "participating provider" refers to the following:

(1) A health care provider that has entered into an agreement with an insurer under IC 27-8-11-3.

(2) A participating provider (as defined in IC 27-13-1-24).

Sec. 7. As used in this chapter, "prior authorization" means a health plan requirement that a health care service be authorized for payment by the health plan before the health care service is provided to a particular covered individual.

Sec. 8. As used in this chapter, "urgent care situation" means a situation in which a covered individual's treating physician has determined that the covered individual's condition is likely to result in:

(1) adverse health consequences or serious jeopardy to the covered individual's life, health, or safety; or

(2) due to the covered individual's psychological state, serious jeopardy to the life, health, or safety of another individual;

unless treatment of the covered individual's condition for which prior authorization is sought occurs earlier than the period generally considered by the medical profession to be reasonable to treat routine or non-life threatening conditions.

Sec. 9. (a) A health plan shall publish on the health plan's Internet web site a list of each policy form or contract form offered by the health plan that requires prior authorization, including:

(1) the applicable CPT code for; and

(2) a plain language description of;

the specific health care services for which prior authorization is required.

(b) A health plan shall make available to participating providers, on the health plan's Internet web site or portal, a list of the health plan's prior authorization requirements, including specific information that a provider must submit to establish a complete request for prior authorization.

(c) A health plan shall, not less than sixty (60) days before the prior authorization requirement becomes effective, disclose to a participating provider any new prior authorization requirement.

(d) A disclosure made under subsection (c) must:

(1) be sent via electronic or United States mail and conspicuously labeled "Notice of Changes to Prior Authorization Requirements"; and

(2) specifically identify the location on the health plan's Internet web site or portal of the new prior authorization requirement.

(e) A participating provider shall, not more than seven (7) days after the change is made, notify the health plan of a change in the participating provider's electronic or United States mail address.

Sec. 10. (a) This section applies to a request for prior authorization delivered to a health plan after December 31, 2019.

(b) A health plan shall accept a request for prior authorization delivered to the health plan by a covered individual's health care provider through an electronic transmission that complies with the technical standards developed for electronic prior authorization transactions by the Council for Affordable Quality Healthcare.

(c) Subsection (b) does not apply if a covered individual's health care provider lacks:

(1) broadband Internet access;

(2) an electronic medical record system; or

(3) a sufficient number of covered individuals as patients or customers, as determined by the commissioner, to warrant the financial expense that compliance with subsection (b) would require.

(d) If a covered individual's health care provider is described in subsection (c), the health plan shall accept from the health care provider a request for prior authorization as follows:

(1) The prior authorization request must be made on the standardized prior authorization form established by the department under section 16(b) of this chapter.

(2) The health plan shall provide for electronic transmission and receipt of the standardized prior authorization form and any supporting information for the prior authorization.

Sec. 11. (a) This section applies to a prior authorization request delivered to a health plan after December 31, 2019.

(b) A health plan shall respond to a request delivered under section 10 of this chapter as follows:

(1) If the request is delivered under section 10(b) of this chapter, the health plan shall immediately send to the requesting health care provider an electronic receipt for the request.

(2) If the request is for an urgent care situation, the health plan shall respond with a prior authorization determination not more than forty-eight (48) hours after receiving the request.

(3) If the request is for a nonurgent care situation, the health plan shall respond with a prior authorization determination not more than seven (7) business days after receiving the request.

(c) If a request delivered under section 10 of this chapter is incomplete:

(1) the health plan shall respond within the period required by subsection (b) and indicate the specific additional information required to process the request; and

(2) if the request was delivered under section 10(b) of this chapter, upon receiving the response under subdivision (1), the health care provider shall immediately send to the health plan an electronic receipt for the response made under subdivision (1).

(d) If a request delivered under section 10 of this chapter is denied, the health plan shall respond within the period required by subsection (b) and indicate the specific reason for the denial.

Sec. 12. (a) This section applies to a claim for a health care service:

(1) for which a health plan gives prior authorization; and

(2) that is rendered in accordance with the prior authorization.

(b) The health plan shall not deny the claim described in subsection (a) unless:

(1) the:

(A) request for prior authorization; or

(B) claim;

contains fraudulent or materially incorrect information; or

(2) the covered individual is not covered under the health plan on the date on which the health care service is rendered.

(c) If:

(1) the claim described in subsection (a) contains an unintentional and inaccurate inconsistency with the request for prior authorization; and

(2) the inconsistency results in denial of the claim;

the health care provider may resubmit the claim with accurate, corrected information.

Sec. 13. (a) This section applies to a claim for a medically necessary health care service, the necessity of which:

(1) is not anticipated at the time prior authorization is obtained for another health care service; and

(2) is determined at the time the other health care service is rendered.

(b) The health plan shall not deny a claim described in subsection (a) based solely on lack of prior authorization for the unanticipated health care service.

Sec. 14. A provision that:

(1) is contained in a policy or contract that is entered into, amended, or renewed after June 30, 2018; and

(2) contradicts this chapter;

is void.

Sec. 15. A violation of this chapter by a health plan is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

Sec. 16. (a) The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

(b) The department shall establish, post, and maintain on the department's Internet web site a standardized prior authorization form for use by health care providers and health plans for

purposes of any notice or authorization required by a health plan with respect to payment for a health care service rendered to a covered individual.

SECTION 3. IC 27-8-28-6, AS AMENDED BY P.L.160-2011, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]: Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:

(1) a determination that a service or proposed service is not appropriate or medically necessary;

(2) a determination that a service or proposed service is experimental or investigational;

(3) the availability of participating providers;

(4) the handling or payment of claims for health care services;

(5) matters pertaining to the contractual relationship between:

(A) a covered individual and an insurer; or

(B) a group policyholder and an insurer; ~~or~~

(6) an insurer's decision to rescind an accident and sickness insurance policy; **or**

(7) a determination concerning a prior authorization request under IC 27-1-37.5;

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.