February 23, 2018

ENGROSSED
HOUSE BILL No. 1143

DIGEST OF HB 1143 (Updated February 22, 2018 11:55 am - DI 97)

Citations Affected: IC 5-10; IC 27-1; IC 27-8.

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, Carbaugh, Austin, Lehman

(SENATE SPONSOR — BROWN L)

January 8, 2018, read first time and referred to Committee on Insurance.
January 25, 2018, amended, reported — Do Pass.
January 29, 2018, read second time, amended, ordered engrossed.
January 30, 2018, engrossed. Read third time, passed. Yeas 91, nays 1.

SENATE ACTION

February 1, 2018, read first time and referred to Committee on Insurance and Financial Institutions.
February 22, 2018, amended, reported favorably — Do Pass.

February 23, 2018

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.

ENGROSSED
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, 11, 12, and 13 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.

(c) This chapter does not apply to a health plan that is offered by a local unit public employer under a program of group health insurance provided under IC 5-10-8-2.6.

Sec. 2. As used in this chapter, "covered individual" means an individual who is covered 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 practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.

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 make available to participating providers on the health plan's Internet web site or portal the applicable CPT code for 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. This subsection does not prevent a health plan from requiring specific additional information upon review of the request for prior authorization.

(c) A health plan shall, not less than forty-five (45) 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.

However, a health plan is considered to have met the requirements of this subsection if the health plan conspicuously posts the information required by this subsection, including the effective date of the new prior authorization requirement, on the health plan's Internet web site.

(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 a secure electronic transmission. A health care provider shall submit a request for prior authorization through a secure electronic transmission. A health plan shall provide for:

(1) a secure electronic transmission; and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.

(c) Subsection (b) does not apply and a health plan that requires prior authorization shall accept a request for prior authorization that is not submitted through a secure electronic transmission if a covered individual's health care provider and the health plan have entered into an agreement under which the health plan agrees to process prior authorization requests that are not submitted through a secure electronic transmission because:

(1) secure electronic transmission of prior authorization requests would cause financial hardship for the health care provider;

(2) the area in which the health care provider is located lacks sufficient Internet access; 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 of this chapter.

(2) The health plan shall provide for secure electronic transmission and acknowledgement of receipt of the standardized prior authorization form and any supporting information for the prior authorization by use of a transaction number or another reference code.

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 seventy-two (72) 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;

(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); and

(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information not more than seventy-two (72) hours after the health care provider receives the response 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 rendered by a participating provider:

(1) for which:

(A) prior authorization is requested after December 31, 2019; and

(B) a health plan gives prior authorization; and

(2) that is rendered in accordance with:

(A) the prior authorization; and

(B) all terms and conditions of the participating provider's agreement or contract with the health plan.

(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 filed after December 31, 2018, for a medically necessary health care service rendered by a participating provider, 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.

(c) The health plan:

(1) shall not deny payment for a health care service that is rendered in accordance with:

(A) a prior authorization; and

(B) all terms and conditions of the participating provider's agreement or contract with the health plan; and

(2) may:

(A) require retrospective review of; and

(B) withhold payment for;

an unanticipated health care service described in subsection (a).

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. 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.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1143, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, line 11, delete "10 and 11" and insert "**10, 11, 12, and 13**".

Page 1, line 16, delete "entitled to coverage" and insert "**covered**".

Page 2, delete lines 34 through 36 and insert "**practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.**".

Page 3, line 7, delete "publish" and insert "**make available to participating providers**".

Page 3, line 8, delete "a list of each policy form or contract form offered" and insert "**or portal the applicable CPT code for the specific health care services for which prior authorization is required.**".

Page 3, delete lines 9 through 13.

Page 3, line 18, after "authorization." insert "**This subsection does not prevent a health plan from requiring specific additional information upon review of the request for prior authorization.**".

Page 3, line 19, delete "sixty (60)" and insert "**forty-five (45)**".

Page 3, line 36, delete "an" and insert "**a secure**".

Page 3, line 36, delete "transmission that complies with the".

Page 3, delete lines 37 through 38 and insert "**transmission. A health care provider shall submit a request for prior authorization through a secure electronic transmission.**".

Page 3, line 39, after "apply" insert "**and a health plan that requires prior authorization shall accept a request for prior authorization that is not submitted through a secure electronic transmission**".

Page 3, line 40, delete "lacks:".

Page 3, delete lines 41 through 42 and insert "**and the health plan have entered into an agreement under which the health plan agrees to process prior authorization requests that are not submitted through a secure electronic transmission because:**

(1) secure electronic transmission of prior authorization requests would cause financial hardship for the health care

provider;

(2) the area in which the health care provider is located lacks sufficient Internet access; or"

Page 4, line 11, after "for" insert "**secure**".

Page 4, line 12, delete "and receipt" and insert "**and acknowledgement of receipt**".

Page 4, line 13, delete "authorization." and insert "**authorization by use of a transaction number or another reference code.**".

Page 4, line 24, delete "forty-eight (48)" and insert "**seventy-two (72)**".

Page 4, line 34, delete "and".

Page 4, line 39, delete "(1)." and insert "**(1); and**

(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information not more than seventy-two (72) hours after the health care provider receives the response under subdivision (1).".

Page 5, delete line 3, begin a new line block indented and insert:

"**(1) for which:**

(A) prior authorization is requested after December 31, 2019; and

(B) a health plan gives prior authorization; and".

Page 5, line 5, delete "authorization." and insert "**authorization and, if the health care provider is a participating provider, all terms and conditions of the participating provider's agreement or contract with the health plan.**".

Page 5, line 21, after "claim" insert "**filed after December 31, 2018,**".

Page 5, between lines 29 and 30, begin a new paragraph and insert:

"**(c) The health plan:**

(1) shall not deny payment for a claim for a health care service that is rendered in accordance with a prior authorization; and

(2) may:

(A) require retrospective review of; and

(B) withhold payment for;

an unanticipated health care service described in subsection (a).".

Page 5, line 38, delete "(a) The commissioner may adopt rules under IC 4-22-2".

Page 5, delete line 39.

Page 5, line 40, delete "(b)".

and when so amended that said bill do pass.

(Reference is to HB 1143 as introduced.)

CARBAUGH

Committee Vote: yeas 12, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1143 be amended to read as follows:

Page 1, between lines 14 and 15, begin a new paragraph and insert:

"**(c) This chapter does not apply to a health plan that is offered by a local unit public employer under a program of group health insurance provided under IC 5-10-8-2.6.**".

Page 3, between lines 30 and 31, begin a new line blocked left and insert:

"**However, a health plan is considered to have met the requirements of this subsection if the health plan conspicuously posts the disclosure on the health plan's Internet web site.**".

Page 5, delete lines 24 through 27, begin a new line block indented and insert:

"**(2) that is rendered in accordance with:**

(A) the prior authorization; and

(B) if the health care provider is a participating provider, all terms and conditions of the participating provider's agreement or contract with the health plan.".

(Reference is to HB 1143 as printed January 26, 2018.)

SCHAIBLEY

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1143, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 3, line 36, delete "disclosure" and insert "**information required by this subsection, including the effective date of the new prior authorization requirement,**".

Page 4, line 4, after "transmission." insert "**A health plan shall provide for:**

(1) a secure electronic transmission; and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.".

Page 4, line 26, delete "16(b)" and insert "**16**".

Page 5, line 25, delete "service:" and insert "**service rendered by a participating provider:**".

Page 5, line 32, delete "if the health care provider is a participating provider,".

Page 6, line 9, delete "service," and insert "**service rendered by a participating provider,**".

Page 6, line 19, delete "a claim for".

Page 6, line 20, delete "with a prior" and insert "**with:**

(A) a prior authorization; and

(B) all terms and conditions of the participating provider's agreement or contract with the health plan;".

Page 6, line 21, delete "authorization;".

and when so amended that said bill do pass.

(Reference is to HB 1143 as reprinted January 30, 2018.)

PERFECT, Chairperson

Committee Vote: Yeas 7, Nays 0.