January 26, 2018

SENATE BILL No. 210

DIGEST OF SB 210 (Updated January 25, 2018 11:24 am - DI 97)

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

Synopsis: Prior authorization. Specifies requirements for prior authorization of health plan coverage and claim payment, including provisions concerning electronic transmission of prior authorization requests and responses, except in certain circumstances.

Effective: July 1, 2018.

Brown L

January 3, 2018, read first time and referred to Committee on Insurance and Financial Institutions.
January 25, 2018, amended, reported favorably — Do Pass.

January 26, 2018

Second Regular Session 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.

SENATE BILL No. 210

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 must 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. Except as provided in section 16 of this chapter, this chapter applies beginning January 1, 2020.

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 services" means health care related services or products rendered or sold by a health care provider within the scope of the health care provider's license or legal authorization and includes 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).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19).

(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 a health plan 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 under 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 approval 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 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 be 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.

Sec. 10. (a) A health plan that requires prior authorization shall accept a request for prior authorization on a prior authorization form that is:

(1) available electronically from the health plan; and

(2) delivered to the health plan by a covered individual's health care provider through a secure electronic transmission.

(b) Subsection (a) does not apply, and a health plan that requires prior authorization shall accept a request for prior authorization that is not submitted electronically, 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 electronically because:

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

or

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

Sec. 11. A health plan shall reply to a prior authorization request submitted electronically under section 10(a) of this chapter by sending an electronic receipt to the health care provider acknowledging receipt of the request.

Sec. 12. (a) The following apply to a request delivered under section 10 of this chapter:

(1) If the request is for an urgent care situation:

(A) the health plan shall respond:

(i) not more than forty-eight (48) hours after receiving the request; and

(ii) indicating whether the request is approved, denied, or incomplete; and

(B) the health care provider shall provide the additional information required as specified under subsection (b) not more than seventy-two (72) hours after the health care provider receives the response from the health plan.

(2) If the request is for a non-urgent care situation, the health plan shall respond:

(A) not more than seven (7) business days after receiving the request; and

(B) indicating whether the request is approved, denied, or incomplete.

(b) If a response under subsection (a) indicates that the request is incomplete, the health plan shall specify in the response the additional information required to process the request.

(c) If a health care plan's response under subsection (a) indicates that the request is denied, the health plan shall state in the health plan's response the specific reason for the denial.

Sec. 13. A health care provider shall reply to a health plan's electronic response indicating an incomplete request under section 12(b) of this chapter by sending an electronic receipt to the health plan acknowledging receipt of the health plan's response and request for additional information.

Sec. 14. If a prior authorization request is denied by a health care plan, the covered individual, or a health care provider on behalf of the covered individual, may file a grievance under IC 27-8-28 or IC 27-13-10, or initiate an external review under IC 27-8-29 or IC 27-13-10.1, whichever is applicable.

Sec. 15. (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 prior authorization for a health care service described in subsection (a) is conclusive proof that the covered individual is covered under the health plan.

(c) If:

(1) the claim 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.

(d) If the health care service is rendered by a participating provider in accordance with:

(1) the prior authorization; and

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

the health plan shall not retroactively deny the prior authorization described in subsection (a).

Sec. 16. (a) This section applies to a claim for a medically necessary health care service rendered after December 31, 2018:

(1) the necessity of which:

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

(B) is determined at the time the other health care service is rendered; and

(2) that is directly related to the other health care service.

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

Sec. 17. If a:

(1) health plan requires prior authorization for a health care service; and

(2) health care provider renders the health care service without obtaining prior authorization;

the health plan shall permit retrospective review for medical necessity of the health care service.

Sec. 18. 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. 19. 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.

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 210, 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 1, line 11, delete "This chapter applies to a prior authorization requested".

Page 1, delete line 12 and insert "**Except as provided in section 16 of this chapter, this chapter applies beginning January 1, 2020.**".

Page 1, line 14, delete "entitled to coverage" and insert "**covered**".

Page 1, line 17, delete "Technology" and insert "**Terminology**".

Page 2, delete lines 30 through 32 and insert "**practice implemented by a health plan under 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 15, delete "thirty (30)" and insert "**forty-five (45)**".

Page 3, delete lines 25 through 28.

Page 4, delete lines 9 through 16, begin a new paragraph and insert:

"**Sec. 12. (a) The following apply to a request delivered under section 10 of this chapter:**

(1) If the request is for an urgent care situation:

(A) the health plan shall respond:

(i) not more than forty-eight (48) hours after receiving the request; and

(ii) indicating whether the request is approved, denied, or incomplete; and

(B) the health care provider shall provide the additional information required as specified under subsection (b) not more than seventy-two (72) hours after the health care provider receives the response from the health plan.".

Page 4, line 19, delete "five (5)" and insert "**seven (7)**".

Page 4, line 24, delete "incomplete:" and insert "**incomplete,**".

Page 4, line 25, delete "(1)".

Page 4, run in lines 24 through 25.

Page 4, line 26, delete "request; and" and insert "**request.**".

Page 4, delete lines 27 through 30.

Page 5, delete lines 7 through 13, begin a new paragraph and insert:

"**(b) The prior authorization for a health care service described in subsection (a) is conclusive proof that the covered individual is covered under the health plan.**".

Page 5, between lines 19 and 20, begin a new paragraph and insert:

"**(d) If the health care service is rendered by a participating provider in accordance with:**

(1) the prior authorization; and

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

the health plan shall not retroactively deny the prior authorization described in subsection (a).".

Page 5, line 21, delete "service:" and insert "**service rendered after December 31, 2018:**".

Page 5, line 28, after "not" insert "**ultimately**".

Page 5, line 31, after "Sec. 17." insert "**If a:**

(1) health plan requires prior authorization for a health care service; and

(2) health care provider renders the health care service without obtaining prior authorization;

the health plan shall permit retrospective review for medical necessity of the health care service.

Sec. 18.".

Page 5, line 36, delete "Sec. 18." and insert "**Sec. 19.**".

Page 5, delete lines 39 through 42.

Delete pages 6 through 9.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 210 as introduced.)

PERFECT, Chairperson

Committee Vote: Yeas 8, Nays 0.