1 **MEDICAL TREATMENT PRIOR AUTHORIZATION**
2 2018 GENERAL SESSION
3 STATE OF UTAH
4 **Chief Sponsor: Evan J. Vickers**
5 House Sponsor: ____________
6
7 **LONG TITLE**
8 **General Description:**
9 This bill amends provisions of the Insurance Code relating to prior authorization and
10 step therapy.
11 **Highlighted Provisions:**
12 This bill:
13 ▸ defines terms;
14 ▸ requires a health insurer to provide certain information about prior authorizations to
15 enrollees and providers;
16 ▸ specifies how prior authorizations may be used by a health insurer;
17 ▸ creates restrictions on the use of prior authorizations in certain circumstances;
18 ▸ beginning January 1, 2019, requires a health insurer to receive prior authorization
19 transactions electronically and in accordance with specified standards;
20 ▸ specifies that the provisions of this bill apply to a health benefit plan renewed or
21 entered into on or after January 1, 2019; and
22 ▸ requires rulemaking by the Insurance Department.
23 **Money Appropriated in this Bill:**
24 None
25 **Other Special Clauses:**
26 None
27 **Utah Code Sections Affected:**

S.B. 224

28 ENACTS:
29 **31A-22-647**, Utah Code Annotated 1953
30
31 *Be it enacted by the Legislature of the state of Utah:*
32 Section 1. Section **31A-22-647** is enacted to read:
33 **31A-22-647. Prior authorization -- Electronic transactions -- Step therapy.**
34 (1) As used in this section:
35 (a) "Adverse determination" means a determination by a health insurer that payment
36 for health care is denied, reduced, or terminated because the health care does not meet the
37 requirements, restrictions, or clinical criteria for prior authorization established under
38 Subsection (2)(a).
39 (b) "Authorization" means a determination by a health care insurer that payment for
40 health care will be made because the health care meets the requirements, restrictions, or clinical
41 criteria for prior authorization established under Subsection (2)(a).
42 (c) "Clinical criteria" means the written criteria used by a health insurer to make an
43 authorization or adverse determination, including:
44 (i) medical practice guidelines;
45 (ii) medical practice protocols, including step therapy protocols; and
46 (iii) drug formulary requirements.
47 (d) "Device" means a prescription device as defined in Section 58-17b-102.
48 (e) "Drug" means the same as that term is defined in Section 58-17b-102.
49 (f) "Emergency facility" means a facility designated under Section 26-8a-303 as an
50 emergency medical service provider.
51 (g) "Emergency health care" means health care provided for an emergency medical
52 condition, as defined in Section 31A-22-627.
53 (h) "Health care" means a professional service, a personal service, a facility,
54 equipment, a device, supplies, or medicine:
55 (i) intended for use in the diagnosis, treatment, mitigation, or prevention of a human
56 ailment or impairment; and
57 (ii) provided by a health care provider licensed under:
58 (A) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

59 (B) Title 58, Occupations and Professions.
60 (i) "Health insurer" means:
61 (i) an insurer that issues a health benefit plan; and
62 (ii) an agent of the health insurer that performs prior authorization functions.
63 (j) "Medically necessary" means, with respect to health care, health care that a prudent
64 physician would provide to a patient for the purpose of preventing, diagnosing, or treating an
65 illness, injury, or disease, or the symptoms of an illness, injury, or disease, in a manner that is:
66 (i) in accordance with generally accepted standards of medical practice;
67 (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and
68 (iii) not based primarily on:
69 (A) the economic consequences to the patient, a health insurer, or others paying for the
70 service; or
71 (B) convenience to the patient or the health care provider.
72 (k) "Participating provider" means a health care provider that has a contractual
73 relationship with a health insurer.
74 (l) "Pre-hospital transportation" means transportation by an emergency medical service
75 provider to an emergency facility.
76 (m) "Prior authorization" means a requirement to obtain an authorization, including:
77 (i) preadmission review;
78 (ii) pretreatment review;
79 (iii) utilization review;
80 (iv) case management; and
81 (v) a health insurer's requirement that an enrollee or the enrollee's health care provider
82 notify the health insurer or another person before the enrollee receives particular health care.
83 (n) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395(e)(3).
84 (o) "Step therapy protocol" means a protocol that establishes the order in which health
85 care must be provided to receive authorization.
86 (p) "Urgent health care" means health care that:
87 (i) if not received by an enrollee within one business day after a request for
88 authorization for the health care:
89 (A) could seriously jeopardize the life or health of the enrollee or the ability of the

90 enrollee to regain maximum function; or
91 (B) could subject the enrollee to severe pain that cannot be adequately managed
92 without the health care; and
93 (ii) is not emergency health care.
94 (2) (a) A health insurer shall:
95 (i) provide the following information to the health insurer's enrollees and participating
96 providers:
97 (A) a list of each drug, device, and service for which prior authorization is required;
98 (B) all requirements, restrictions, and clinical criteria for prior authorization; and
99 (C) a description of the types of information a health care provider or enrollee must
100 submit to the health insurer to receive authorization for each drug, device, or service, including,
101 if applicable, the results of a face-to-face clinical evaluation or a second opinion;
102 (ii) make the information required by Subsection (2)(a)(i) available:
103 (A) on a website that is accessible to the health insurer's enrollees and participating
104 providers; and
105 (B) in language that is detailed and easy to understand; and
106 (iii) publish on a regular basis, for each request for authorization that the health insurer
107 has received over the past five years, on the website described in Subsection (2)(a)(ii)(A), the
108 following information, in a manner that is consistent with federal and state law:
109 (A) the drug, device, or service for which prior authorization was requested;
110 (B) if a health care provider made the request on behalf of an enrollee, the health care
111 provider's practice specialty;
112 (C) a brief description of the reason for the request; and
113 (D) the determination made by the health insurer in response to the request.
114 (b) A health insurer may not modify a prior authorization requirement unless the health
115 insurer provides the health insurer's participating providers with written notice of the
116 modification on the website described in Subsection (2)(a)(ii)(A) at least 60 days before the
117 day on which the modification takes effect.
118 (3) (a) Upon receiving a request for authorization that includes the information
119 required by the insurer under Subsection (2)(a)(i)(C), a health insurer shall notify the person
120 making the request, in accordance with the requirements described in Subsection (9), of the

121 health insurer's authorization or adverse determination:
122 (i) within 60 minutes from the time that the health insurer receives the request, if the
123 request is for authorization for health care that is required immediately after the provision of
124 emergency health care;
125 (ii) within one business day after the health insurer receives a request, if the request is
126 for authorization for health care that is urgent health care; and
127 (iii) within two business days after the health insurer receives a request, if the request is
128 for authorization for health care that is not described in Subsection (3)(a)(i) or (ii).
129 (b) In addition to the enforcement penalties and procedures described in Section
130 31A-2-308, if the health insurer does not notify the enrollee or health care provider in
131 accordance with the time frames described in Subsection (3)(a) or if the health insurer violates
132 any provision of this section as to a particular authorization, authorization is considered granted
133 by the health insurer.
134 (c) (i) If a health insurer makes an adverse determination, the notification shall include
135 the reasons for the adverse determination, including reference to specific information required
136 by the health insurer under Subsection (2)(a)(i)(C).
137 (ii) The health insurer shall ensure that an adverse determination is made by an
138 individual licensed as a physician, as defined in Section 58-67-102, who:
139 (A) has knowledge of and experience with managing the medical condition or disease
140 of the enrollee for whom the authorization is requested; or
141 (B) consults with a physician who has knowledge of and experience with managing the
142 medical condition or disease of the enrollee for whom the authorization is requested regarding
143 the request before making the determination.
144 (iii) The reviewing physician shall make an adverse determination under the clinical
145 supervision of one of the health insurer's medical directors who is licensed as a physician, as
146 defined in Section 58-67-102, in Utah and who is responsible for supervising the provision of
147 health care services to enrollees in Utah.
148 (d) If a request for authorization under Subsection (3)(a) is missing information
149 required by an insurer under Subsection (2)(a)(i)(B), the health insurer shall notify the person
150 making the request of the missing information within the time periods established in
151 Subsection (3)(a).

152 (e) (i) An authorization under Subsection (3)(a) or (b) is valid for one year, unless the
153 authorization is amended or revoked.
154 (ii) An authorization under Subsection (3)(a) or (b) may not be amended or revoked for
155 45 days after the authorization is given under Subsection (3)(a) or considered granted under
156 Subsection (3)(b).
157 (4) (a) Except as provided in Subsection (4)(b), a health insurer is not required to pay a
158 claim for health care if the health care:
159 (i) is subject to prior authorization; and
160 (ii) was not authorized under Subsection (3)(a) or (b).
161 (b) Health care is not subject to a prior authorization requirement if:
162 (i) the health care for which the authorization is normally required is directly related to
163 health care for which authorization has already been given; and
164 (ii) the health care provider did not know that the health care for which authorization is
165 normally required was needed until the health care provider provided the health care that was
166 authorized or did not require authorization.
167 (5) (a) A health insurer may not:
168 (i) require any form of preauthorization for emergency health care until after the
169 enrollee's condition has been stabilized; or
170 (ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered
171 treatment considered medically necessary to stabilize the enrollee's emergency medical
172 condition, as defined in Section 31A-22-627.
173 (b) In making a determination of whether the emergency health care received by the
174 enrollee is medically necessary or medically appropriate, the health insurer shall ensure that the
175 determination is made without regard to whether the provider of the emergency health care is
176 one of the health insurer's participating providers.
177 (6) A health insurer shall pay a claim from a health care provider if:
178 (a) a health insurer has approved at least 90% of the requests for authorization from a
179 health care provider over the previous year for:
180 (i) a particular CPT code for a particular medication; or
181 (ii) a particular ICD-10 diagnosis code;
182 (b) the health care provider that meets the requirement in Subsection (6)(a) has

183 established those facts with the health insurer;
184 (c) the health care provider submits a claim that would normally require authorization
185 without any authorization; and
186 (d) the health care provider represents that, to the best of the health care provider's
187 knowledge and understanding, the claim meets all of the health insurer's requirements for
188 authorization.
189 (7) (a) A health insurer shall provide, in the health insurer's requirements for
190 authorization, an allowance for continuity of care for an enrollee who is undergoing an active
191 course of treatment when there is a formulary or treatment coverage change or a change of
192 health plan that might otherwise disrupt the enrollee's current course of treatment.
193 (b) A health insurer shall support continuity of care for medical services and
194 prescription medications for enrollees on appropriate, chronic, stable therapy by minimizing
195 repetitive prior authorization requirements.
196 (8) A health insurer may not apply prior authorization to pre-hospital transportation.
197 (9) (a) Beginning January 1, 2019, a health insurer shall accept requests for
198 authorization under Subsection (3):
199 (i) for authorization of medical services, through a secure electronic transmission that
200 meets the requirements for the transmission of health data established by the Accredited
201 Standards Committee X12; or
202 (ii) for a device dispensed by a pharmacy or a drug covered under a pharmacy benefit
203 program or prescription drug program:
204 (A) the most recent standard adopted by the department to address transmission of
205 prescription information electronically between prescribers, pharmacies, health insurers, and
206 other entities; or
207 (B) the most recent SCRIPT standard by the National Council for Prescription Drug
208 Program that is compatible with version 201310 of the SCRIPT standard, if that SCRIPT
209 standard is adopted by the United States Department of Health and Human Services.
210 (b) A facsimile communication, proprietary payer portal, or electronic form is not a
211 secure electronic transmission under Subsection (9)(a).
212 (c) A health insurer that receives a request for authorization from a health care provider
213 in accordance with Subsection (9)(a) shall immediately confirm receipt of the request to the

214 health care provider by the same means through which the request for authorization was
215 received.
216 (10) A health insurer may not prohibit resubmission of a claim solely because the claim
217 was originally submitted with erroneous information.
218 (11) (a) A health insurer shall pay a claim for health care that is subject to step therapy
219 if:
220 (i) the health care is provided in accordance with the health insurer's step therapy
221 protocol; or
222 (ii) (A) the health care is not provided in accordance with the health insurer's step
223 therapy protocol; and
224 (B) the health care provider that provides the health care determines that the step
225 therapy protocol is not in the enrollee's best interest.
226 (b) A health insurer may not, as a condition of paying a claim, require a health care
227 provider who believes that certain health care under a step therapy protocol is not in the
228 enrollee's best interest, to obtain a waiver, exception, override, or other form of approval by the
229 health insurer before the health care provider provides the health care.
230 (c) A health insurer may not sanction or otherwise penalize a health care provider for
231 determining that a step therapy protocol is not in an enrollee's best interest.
232 (12) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
233 Administrative Rulemaking Act, and in consultation with the Physicians Licensing Board,
234 created in Section 58-67-201, and the Osteopathic Physician and Surgeon's Licensing Board,
235 created in Section 58-68-201:
236 (a) define for the purposes of this section:
237 (i) "business day"; and
238 (ii) "practice specialty"; and
239 (b) adopt standards for the transmission of prescription information.
240 (13) This section applies to a health benefit plan renewed or entered into on or after
241 January 1, 2019.

Legislative Review Note
Office of Legislative Research and General Counsel