HOUSE BILL No. 2283

By Committee on Insurance

2-2

AN ACT concerning health and healthcare; relating to insurance; enacting the ensuring transparency in prior authorization act; imposing certain requirements and limitations on the use of prior authorization.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) Sections 1 through 9, and amendments thereto, shall be known and may be cited as the ensuring transparency in prior authorization act.

(b) Sections 1 through 9, and amendments thereto, shall be a part of and supplemental to article 32 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

(c) As used in sections 1 through 9, and amendments thereto:

(1) "Healthcare services" means services provided to an individual to prevent, alleviate, cure or heal human illness or injury. "Healthcare services" includes, but is not limited to: Medical, chiropractic, dental or vision services; hospitalization; pharmaceutical services; or care or services incidental to services described in this paragraph.

(2) "Physician" means an individual licensed by the state board of healing arts to practice medicine and surgery.

(3) "Prior authorization" means a determination that: (A) Healthcare services proposed to be provided to a patient are medically necessary and appropriate; and (B) is made by an insurance company, health maintenance organization or person contracting with an insurance company or health maintenance organization.

(4) "Provider" means a:

(A) Person licensed by the state board of healing arts to practice any branch of the healing arts;

(B) person who holds a temporary permit issued by the state board of healing arts to practice any branch of the healing arts;

(C) medical care facility, as defined in K.S.A. 65-425, and amendments thereto, that is licensed by the state of Kansas;

(D) podiatrist licensed by the state board of healing arts;

(E) health maintenance organization issued a certificate of authority by the commissioner of insurance;

(F) optometrist licensed by the board of examiners in optometry;

(G) pharmacist licensed by the state board of pharmacy;

(H) licensed professional nurse who is authorized by the board of nursing to practice as a registered nurse anesthetist;

(I) licensed professional nurse who has been granted a temporary authorization to practice nurse anesthesia under K.S.A. 65-1153, and amendments thereto;

(J) physician assistant licensed by the state board of healing arts;

(K) licensed advanced practice registered nurse who is certified by the board of nursing in the role of registered nurse anesthetist while functioning as a registered nurse anesthetist;

(L) licensed advanced practice registered nurse who has been granted an authorization by the board of nursing to practice in the role of certified nurse-midwife;

(O) dentist licensed by the Kansas dental board under the dental practices act; or

(P) person licensed, registered, certified or otherwise authorized by the behavioral sciences regulatory board to practice a profession.

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

(A) An employer with employees in Kansas who are covered under a health benefit plan or health insurance policy;

(B) an insurer that writes health insurance policies;

(C) a preferred provider organization or health maintenance organization; or

(D) 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 healthcare professional in Kansas under a policy, plan or contract.

Sec. 2. (a) Not later than January 1, 2024, a utilization review entity shall accept and respond to prior authorization requests under a pharmacy benefit through a secure electronic transmission using the national council for prescription drug programs script standard for electronic prior authorization transactions. As used in this subsection, "secure electronic transmission" does not include facsimile, proprietary payer portals, electronic forms or any other technology that is not directly integrated with a physician's electronic health record or electronic prescribing system.

(b) Not later than January 1, 2024, a utilization review entity shall accept and respond to prior authorization requests for healthcare services using a secure electronic portal at no cost to a healthcare provider. A utilization review entity shall not require a healthcare provider to use a specified secure electronic portal.

Sec. 3. (a) Not later than 24 hours after receiving all information requested to complete a review of requested urgent healthcare services, a utilization review entity shall:

1 (1) Render a prior authorization or adverse determination and notify
2 the enrollee and enrollee's healthcare provider of such prior authorization
3 or adverse determination; and
4 (2) if the utilization review entity determines that additional
5 information is needed to render a prior authorization or adverse
6 determination, notify the healthcare provider that additional information is
7 needed.
8 (b) (1) A utilization review entity shall not require prior authorization
9 for pre-hospital transportation or the provision of emergency healthcare
10 services.
11 (2) A utilization review entity shall allow an enrollee and the
12 enrollee's healthcare provider not less than 24 hours following an
13 emergency admission or the provision of emergency healthcare services to
14 notify the utilization review entity of such admission or provision of
15 services. If an emergency admission or the provision of emergency
16 healthcare services occurs on a weekend or public holiday, a utilization
17 review entity shall not require notification until the next business day after
18 such admission or provision of services.
19 (3) Not later than two hours after receiving all information requested
20 to complete a review of requested emergency healthcare services, a
21 utilization review entity shall:
22 (A) Render a prior authorization or adverse determination and notify
23 the enrollee and enrollee's healthcare provider of such prior authorization
24 or adverse determination; and
25 (B) if the utilization review entity determines that additional
26 information is needed to render a prior authorization or adverse
27 determination, notify the healthcare provider that additional information is
28 needed.
29 (4) If a patient receives emergency healthcare services that require an
30 immediate post-evaluation or post-stabilization, a utilization review entity
31 shall render a prior authorization or adverse determination not later than
32 two hours after receiving the request for such post-evaluation or post-
33 stabilization.
34 (c) After receiving all information requested to complete a review of
35 regular healthcare services, a utilization review entity shall:
36 (1) Not later than 14 calendar days after such receipt, render a prior
37 authorization or adverse determination and notify the enrollee and
38 enrollee's healthcare provider of such prior authorization or adverse
39 determination; and
40 (2) if the utilization review entity determines that additional
41 information is needed to render a prior authorization or adverse
42 determination, not later than 48 hours after such receipt, notify the
43 healthcare provider that additional information is needed.

(d) If a utilization review entity requires a prior authorization for a healthcare service for the treatment of a chronic or long-term care condition:

(1) Such prior authorization shall remain valid for the length of the treatment; and

(2) the utilization review entity shall not require the enrollee to obtain an additional prior authorization for such healthcare service.

Sec. 4. A utilization review entity shall not:

(a) Require prior authorization for birth by cesarean section or vaginal delivery or neonatal intensive care services; or

(b) require notification of such services as a condition of payment for such services.

Sec. 5. (a) A utilization review entity shall not retroactively deny prior authorization for a covered healthcare service unless the prior authorization was based on fraudulent information provided by an enrollee or the enrollee's healthcare provider.

(b) A utilization review entity shall not revoke, limit, condition or restrict a prior authorization if the healthcare service subject to the prior authorization is:

(1) Initiated within 45 business days after the date the healthcare provider received the prior authorization; and

(2) completed within the approved time period.

Sec. 6. (a) A healthcare provider may appeal any adverse determination of a prior authorization request.

(b) Except as provided by subsection (c), a utilization review entity shall complete adjudication of any requested appeal of an adverse determination of a prior authorization request within 30 calendar days.

(c) If a healthcare provider indicates that a requested appeal is an emergency, the utilization review entity shall provide for an expedited phone appeal within 24 hours after the request. If the provider indicates that the requested appeal is urgent, the utilization review entity shall provide for such appeal within 72 hours after the request.

(d) A healthcare provider may prospectively request peer-to-peer review in any appeal of an adverse determination of a prior authorization request. If requested, such review shall be completed within 48 hours after the request. For any appeal that includes a peer-to-peer review, the utilization review committee shall provide a qualified peer who has practiced in the same or similar specialty as the requesting healthcare provider.

Sec. 7. (a) A health maintenance organization or insurer that uses a prior authorization process for healthcare services shall exempt a provider from prior authorization requirements for a specific healthcare service if, in the most recent six-month evaluation period, the health maintenance

organization or insurer has approved or would have approved not less than 90% of the prior authorization requests submitted by the provider for such specific healthcare service.

(b) Any health maintenance organization or insurer that uses a prior authorization process for healthcare services shall determine during January and July of each year which providers and specific healthcare services qualify for exemption under subsection (a). Such determinations shall be based on a retrospective review of a random sample of not fewer than five but not more than 20 claims submitted by the provider during the most recent evaluation period.

(c) If a health maintenance organization or insurer determines that a provider qualifies for exemption under subsection (a), the health maintenance organization or insurer shall notify the provider. Such notification shall include:

(1) The list of healthcare services and health benefit plans to which the exemption applies; and

(2) a statement of the effective date and duration of the exemption.

(d) A health maintenance organization or insurer shall not deny or reduce payment to a provider for a healthcare service for which the provider has qualified under subsection (a) for an exemption from prior authorization requirements.

(e) (1) If a provider has previously qualified for exemption under subsection (a) but the health maintenance organization or insurer subsequently rescinds such exemption, the health maintenance organization or insurer shall notify the provider. Such notification shall include:

(A) A plain language explanation of how the provider may appeal and seek independent review of such rescission; and

(B) the sample information used to justify the rescission.

(2) A health maintenance organization or insurer shall pay the cost of any appeal or independent review of any rescission described in this subsection.

(f) A provider's exemption from pre-authorization requirements shall remain in effect until 90 calendar days after the date that the health maintenance organization or insurer notifies the provider of the determination to rescind the exemption, if the provider does not appeal. If a provider appeals a rescission, then the exemption shall remain in effect during the pendency of the appeal or independent review.

Sec. 8. (a) Each utilization review entity shall disclose all of the utilization review entity's requirements and restrictions related to prior authorization. Such requirements and restrictions shall be disclosed in a publicly accessible manner on the utilization review entity's website.

(b) A utilization review entity shall provide notice of any change to

the utilization review entity's prior authorization requirements or restrictions to each healthcare provider subject to such requirements or restrictions.

(c) On or before January 1, 2024, and annually thereafter, each utilization review entity shall submit a report to the commissioner of insurance providing statistics about the utilization review entity's prior authorization practices. Such statistics shall include, but not be limited to, the:

(1) Percentage of initial approvals and initial adverse determinations;

(2) percentage of initial adverse determinations categorized by healthcare specialty;

(3) largest percentage of medication and diagnostic test adverse determinations;

(4) reasons most frequently cited for adverse determinations;

(5) number of appeals requested; and

(6) percentage of appeals approved and denied.

(d) On or before January 1, 2024, and annually thereafter, the insurance commissioner shall publish on the insurance commissioner's website all reports submitted pursuant to subsection (c).

Sec. 9. If any provision of the ensuring transparency in prior authorization act or the application thereof to any person or circumstance is held invalid or unconstitutional by court order, then the remainder of the ensuring transparency in prior authorization act and the application thereof to other persons or circumstances shall not be affected. It shall be conclusively presumed that the legislature would have enacted the remainder of the ensuring transparency in prior authorization act without such invalid or unconstitutional provision.

Sec. 10. This act shall take effect and be in force from and after its publication in the Kansas register.