



Model ePA Legislation

IN THE GENERAL ASSEMBLY STATE OF _____

Be it enacted by the People of the State of _____

Section I, Title XXXX: This Act may be known and cited as the “Electronic Prior Authorization” Act.

Section II. Purpose. The Legislature hereby finds and declares that:

- a) The physician-patient relationship is essential;
- b) Prior authorization programs should be adopted that provide for cost reduction, efficiency, transparency and reduce burden;
- c) Prior authorization programs shall not hinder patient care; and
- d) Prior authorization programs must include the use of consistent, evidence-based, written clinical criteria.

Section III. Definitions:

- a) “Adverse determination” means a decision by a utilization review entity that the health care services or medications furnished or proposed to be furnished to a subscriber are not medically necessary, or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated.
- b) “Authorization” means a determination by a utilization review entity that a health care service or medication has been reviewed and, based on the information provided, satisfies the utilization review entity’s requirements for medical necessity and appropriateness.
- c) “Clinical criteria” means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of the requested health care service(s) or medication(s).
- d) “Emergency health care services” means those health care services that are provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (i) placing the patient’s health in serious jeopardy; (ii) serious impairment to bodily function; or (iii) serious dysfunction of any bodily organ or part.
- e) “Health care service” means health care procedures, treatments or services: (i) provided by a facility licensed in (indicate the name of the state); or (ii) provided by a doctor of medicine, a doctor of osteopathy, or within the scope of practice for which a health care professional is licensed in (indicate the name of the state). The term “health care service” also includes the provision of pharmaceutical products or services or durable medical equipment.
- f) “Medically necessary health care services” means health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate in terms of type, frequency, extent, site and duration.
- g) “NCPDP SCRIPT Standard” means the National Council for Prescription Drug Programs SCRIPT Standard Version 2013101, or the most recent standard adopted by the United States Department of Health and Human Services (HHS).
- h) “Prior authorization” means the process by which utilization review entities determine the medical necessity and/or medical appropriateness of otherwise covered health care services prior to the rendering of such health care services including, but not limited to, preadmission review, pretreatment review, utilization, and case



management. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to providing a health care service.

- i) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular subscriber are authorized by a utilization review entity.
- j) "Subscriber" means an individual eligible to receive health care benefits by a health insurer pursuant to a health plan or other health insurance coverage. The term "subscriber" includes a subscriber's legally authorized representative.
- k) "Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited prior authorization, which, in the opinion of a physician with knowledge of the subscriber's medical condition: (i) could seriously jeopardize the life or health of the subscriber or the ability of the subscriber to regain maximum function; or (ii) could subject the subscriber to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.
- l) "Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following entities: (i) an employer with employees in _____ (indicate name of state) who are covered under a health benefit plan or health insurance policy; (ii) an insurer that writes health insurance policies; (iii) a preferred provider organization, or health maintenance organization; and (iv) any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care professional in _____ (indicate name of state) under a policy, plan, or contract. A health insurer is a utilization review entity if it performs prior authorization

Section III. Disclosure and review of prior authorization requirements.

A utilization review entity shall make any current prior authorization requirements and restrictions readily accessible on its Web site to subscribers, health care professional, and the general public. This includes the written clinical criteria. Requirements shall be described in detail but also in easily understandable language.

- a) If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement is not implemented unless the utilization review entity's Web site has been updated to reflect the new or amended requirement or restriction.
- b) If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall provide contracted health care providers of written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented.
- c) Entities utilizing prior authorization shall make statistics available regarding prior authorization approvals and denials on their Web site in a readily accessible format. They should include categories for:
 - i. Physician specialty;
 - ii. Medication or diagnostic test/procedure;
 - iii. Indication offered; and
 - iv. Reason for denial.

Section IV: Utilization review entity's obligations with respect to prior authorizations in non-urgent circumstances.

If a utilization review entity requires prior authorization of a health care service, the utilization review entity must make a prior authorization or adverse determination and notify the subscriber and the subscriber's health care provider of the prior authorization or adverse determination within two (2) working days of obtaining all necessary information to make the prior authorization or adverse determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required. As it relates to notification



of determination to the subscriber's health care provider, delivery of the notification via the NCPDP SCRIPT Standard transactions shall satisfy the requirement of notification to the health care provider.

Section V: Utilization review entities' obligations with respect to prior authorizations concerning urgent health care services.

A utilization review entity must render a prior authorization or adverse determination concerning urgent care services, and notify the subscriber and the subscriber's health care provider of that prior authorization or adverse determination not later than one (1) business day after receiving all information needed to complete the review of the requested health care services. As it relates to notification of determination to the subscriber's health care provider, delivery of the notification via the NCPDP SCRIPT Standard transactions shall satisfy the requirement of notification to the health care provider.

Section VI: Appropriate use of step therapy protocols.

A utilization review entity shall not:

- a) Require a health care provider offering services to a subscriber to participate in a step therapy protocol if the provider deems that the step therapy protocol is not in the patient's best interests;
- b) Require that a health care provider first obtain a waiver, exception, or other override when deeming a step therapy protocol to not be in a patient's best interests.
- c) Sanction or otherwise penalize a health care provider for recommending or issuing a prescription, performing or recommending a procedure or performing a test that may conflict with the step therapy protocol of the health insurer or health insurance plan.

Section VII. Length of prior authorization.

A prior authorization shall be valid for one year from the date the health care provider receives the prior authorization.

[Drafting Note: Alternatively, states may want to connect this provision for prescription drugs to the statutory length of a prescription under their Pharmacy Practice Act, if it is greater than one year .]

Section VII. Electronic standards for prior authorization.

No later than January 1, 20XX, the payer must accept and respond to prior authorization requests under the pharmacy benefit, from the prescriber or pharmacist through a secure electronic transmission using standards developed by an organization accredited by the American National Standards Institute, such as but not limited to, the National Council for Prescription Drug Program SCRIPT Standard ePA transactions. Facsimile, propriety payer portals, and electronic forms shall not be considered electronic transmission.