SB3822

LRB10119656BMS69144b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB3822

Introduced 2/14/2020, by Sen. Linda Holmes

SYNOPSIS AS INTRODUCED:

New Act
215 ILCS 134/45.2
215 ILCS 134/70
305 ILCS 5/5-5.12d new

Creates the Prior Authorization Reform Act. Provides requirements concerning disclosure and review of prior authorization requirements, denial of claims or coverage by a utilization review program, and the implementation of prior authorization requirements or restrictions. Provides requirements concerning a utilization review program's obligations with respect to prior authorizations in nonurgent circumstances, urgent health care services, and emergency health care services. Provides that a utilization review program shall not require prior authorization under specified circumstances. Provides requirements concerning the length of prior authorizations. Provides that health care services are automatically deemed authorized if a utilization review program fails to comply with the requirements of the Act. Provides that the Director of Insurance may impose an administrative fine not to exceed $250,000 for violations of the Act. Defines terms. Amends the Managed Care Reform and Patient Rights Act to provide that an insurer that provides prescription drug benefits must comply with the requirements of the Prior Authorization Reform Act. Provides that if prior authorization for covered post-stabilization services is required by a health care plan, the plan shall comply with the requirements of the Prior Authorization Reform Act. Amends the Illinois Public Aid Code to provide that all managed care organizations shall comply with the requirements of the Prior Authorization Reform Act. Makes other changes. Effective January 1, 2021.

LRB101 19656 BMS 69144 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Prior Authorization Reform Act.

Section 5. Purpose. The General Assembly hereby finds and declares that:

(a) the health care professional-patient relationship is paramount and should not be subject to third-party intrusion;

(b) prior authorization programs shall not be permitted to hinder patient care or intrude on the provision of health care services; and

(c) prior authorization programs must be transparent to ensure a fair and consistent process for patients.

Section 10. Applicability; scope. This Act applies to individual and group policies of accident and health insurance, and policies issued or delivered in this State to the Department of Healthcare and Family Services and providing coverage to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act, amended, delivered, issued, or renewed on or after the effective date of this Act, with the exception

of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974, health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act, and State employee health plans. This Act does not diminish a health care plan's duties and responsibilities under other federal or State law or rules promulgated thereunder.

Section 15. Definitions. As used in this Act:

"Adverse determination" means a determination by a utilization review program that, based upon the information provided, the health care services or level of services furnished or a request for health care services or level of services to be furnished to an enrollee do not meet the utilization review program's requirements for medical necessity, appropriateness, health care setting, level of service, or effectiveness or is determined to be experimental or investigational and the requested benefit coverage is therefore denied, reduced, or terminated and payment is not provided or made, in whole or in part, for the health care service.

"Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination.

"Authorization" means a determination by a utilization review program that a health care service has been reviewed and, based on the information provided, satisfies the

utilization review program's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

"Clinical review criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, decision rules, decision abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review program to determine the necessity and appropriateness of health care services.

"Department" means the Department of Insurance.

"Emergency health care services" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, regardless of the final diagnosis given, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to

another hospital before delivery; or

(B) a transfer to another hospital that may pose a threat to the health or safety of the woman or unborn child.

"Enrollee" means a person and his or her dependents enrolled in or covered by a health plan or other health insurance coverage. "Enrollee" includes an enrollee's legally authorized representative.

"Health care professional" means a physician licensed to practice medicine in all its branches, an advanced practice registered nurse, or another individual appropriately licensed or registered to provide health care services.

"Health care provider" means a hospital, hospital facility licensed under the Nursing Home Care Act, or long-term care facility as defined in Section 1-113 of the Nursing Home Care Act.

"Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health, and pharmaceutical services and products.

"Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a

patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party.

"Physician" means a person licensed under the Medical Practice Act of 1987 to practice medicine in all its branches.

"Prior authorization" means the process by which utilization review programs determine the medical necessity and medical appropriateness of otherwise covered health care services for which payment will be made prior to the rendering of such health care services. "Prior authorization" includes any utilization review program's requirement that an enrollee, health care professional, or health care provider notify the utilization review program prior to, at the time of, or concurrent to providing a health care service.

"Urgent health care service" means a health care service with respect to which the application of the time periods for making a nonexpedited prior authorization that in the opinion of a health care professional with knowledge of the enrollee's medical condition:

(1) could seriously jeopardize the life or health of

the enrollee or the ability of the enrollee to regain maximum function; or

(2) could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

"Utilization review program" means a program established to perform prior authorization for or designated by one or more of the following entities:

(1) an employer with employees in Illinois who are covered under a health benefit plan or health insurance policy;

(2) an insurer that offers or issues health insurance policies;

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

(4) a pharmacy benefits manager responsible for managing access of enrollees to available pharmaceutical or pharmacological care; or

(5) any other individual or program that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care professional or health care provider in Illinois under a policy, plan, or contract.

Section 20. Disclosure and review of prior authorization requirements.

(a) A utilization review program shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the utilization review program.

(b) A utilization review program shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals, health care providers, and the general public. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate, for each service subject to prior authorization:

(1) when prior authorization became required for policies issued or delivered in Illinois, including the effective date or dates and the termination date or dates, if applicable, in Illinois;

(2) the date the Illinois-specific requirement was listed on the utilization review program's website; and

(3) where applicable, the date that prior authorization was removed for Illinois.

(c) The clinical review criteria must:

(1) be based on nationally recognized standards;

(2) be developed in accordance with the current

standards of national medical accreditation entities;

(3) reflect community standards of care;

(4) ensure quality of care and access to needed health care services;

(5) be evidence-based;

(6) be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis;

(7) be evaluated and updated, if necessary, at least annually; and

(8) before establishing or substantially or materially altering written clinical review criteria, obtain input from actively practicing physicians, representing major areas of the specialty, within the provider network and within the service area where the written clinical review criteria are to be employed. The utilization review program shall seek input from physicians who are not employees of utilization review program or consultants to the utilization review program.

(d) A utilization review program shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(e) A utilization review program shall not deny coverage of a health care service solely based on the grounds that the health care service does not meet an evidence-based standard where:

(1) no independently-developed, evidence-based standards can be derived from documents published by professional societies;

(2) evidence-based standards conflict;

(3) evidence-based standards from expert consensus panels do not exist; or

(4) existing standards for a particular health care item, service, pharmaceutical product, test, or imaging procedure not directly applicable to the applicable health service are being applied.

(f) A utilization review program shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(1) an associated health care service has received prior authorization; or

(2) prior authorization for the health care service is not required.

(g) If a utilization review program intends to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the utilization review program shall provide contracted enrollees, health care professionals, and health care providers of enrollees written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. The written notice may be provided in an electronic format, including email or facsimile, if the

enrollee, health care professional, or health care provider has agreed in advance to receive notices electronically. The utilization review program shall ensure that the new or amended requirement is not implemented unless the utilization review program's public website has been updated to reflect the new or amended requirement or restriction.

(h) Entities utilizing prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. The categories must be updated monthly and include all of the following information:

(1) a list of all health care services, including medications, that are subject to prior authorization;

(2) the total number of prior authorization requests received;

(3) the physician specialty;

(4) the number of prior authorization requests approved during the previous plan year by the utilization review program with respect to each service described in paragraph (1);

(5) the number of prior authorization requests approved during the previous plan year by the utilization review program after the receipt of additional information from the enrollee, the enrollee's health care professional, or the enrollee's health care provider;

(6) the number of prior authorization requests denied

during the previous plan year by the insurer with respect to each service described in paragraph (1) and the top 10 reasons for denial, which must include related evidence-based criteria, if applicable;

(7) the number of requests described in paragraph (6) that were appealed, the number of the appealed requests that upheld the adverse determination, and the number of appealed requests that reversed the adverse determination;

(8) the time between submission and response;

(9) the average length of time for resolution; and

(10) any other information as the Director determines appropriate after consultation with and comment from stakeholders.

Section 25. Utilization review program's obligations with respect to prior authorizations in nonurgent circumstances. If a utilization review program requires prior authorization of a health care service, the utilization review program must make a prior authorization or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the prior authorization or adverse determination within 48 hours 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.

Section 30. Utilization review program's obligations with respect to prior authorizations concerning urgent health care services.

(a) A utilization review program must render a prior authorization or adverse determination concerning urgent care services and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of that prior authorization or adverse determination not later than 24 hours after receiving all information needed to complete the review of the requested health care services.

(b) To facilitate the rendering of a prior authorization in accordance with this Section, a utilization review program must establish and provide access to a hotline that is staffed 24 hours per day, 7 days per week by appropriately trained and licensed clinical personnel who have access to physicians for consultation, designated by the plan to make such determinations for prior authorization concerning urgent care services.

Section 35. Utilization review program's obligations with respect to prior authorization concerning emergency health care services.

(a) A utilization review program may not require prior authorization for pre-hospital transportation or for the

provision of emergency health care services.

(b) A utilization review program shall allow an enrollee, the enrollee's health care professional, and the enrollee's health care provider a minimum of 24 hours following an emergency admission or provision of emergency health care services for the enrollee, the enrollee's health care professional, or the enrollee's health care provider to notify the utilization review program of the admission or provision of health care services. If the admission or health care service occurs on a holiday or weekend, a utilization review program cannot require notification until the next business day after the admission or provision of the health care services.

(c) A utilization review program shall cover emergency health care services necessary to screen and stabilize an enrollee. If a health care professional or health care provider certifies in writing to a utilization review program within 72 hours after an enrollee's admission that the enrollee's condition required emergency health care services, that certification will create a presumption that the emergency health care services were medically necessary and such presumption may be rebutted only if the utilization review program can establish, with clear and convincing evidence, that the emergency health care services were not medically necessary.

(d) The medical necessity or appropriateness of emergency health care services cannot be based on whether or not those

services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency health care services provided by nonparticipating providers cannot be greater than restrictions that apply when those services are provided by participating providers.

(e) If an enrollee receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a utilization review program shall make an authorization determination within 60 minutes after receiving a request; if the authorization determination is not made within 60 minutes, such services shall be deemed approved.

Section 40. Personnel qualified to make adverse determinations. A utilization review program must ensure that all adverse determinations are made by a physician. The physician must:

(1) possess a current and valid nonrestricted license to practice medicine in all its branches in Illinois;

(2) practice in the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request;

(3) have experience treating patients with the medical condition or disease for which the health care service is being requested; and

(4) make the adverse determination under the clinical

direction of one of the utilization review program's medical directors who is responsible for the provision of health care services provided to enrollees of Illinois. All such medical directors must be physicians licensed in Illinois.

Section 45. Consultation prior to issuing an adverse determination. If a utilization review program is questioning the medical necessity of a health care service, the utilization review program must notify the enrollee's health care professional and health care provider that medical necessity is being questioned. Prior to issuing an adverse determination, the enrollee's health care professional and health care provider must have the opportunity to discuss the medical necessity of the health care service on the telephone or by other agreeable method with the physician who will be responsible for determining authorization of the health care service under review.

Section 50. Requirements applicable to the physician who can review consultations and appeals. A utilization program must ensure that all appeals are reviewed by a physician. The physician must:

(1) possess a current and valid nonrestricted license to practice medicine in Illinois;

(2) be currently in active practice in the same or

similar specialty as physician who typically manages the medical condition or disease for at least 5 consecutive years;

(3) be knowledgeable of, and have experience providing, the health care services under appeal;

(4) not be employed by a utilization review program or be under contract with the utilization review program other than to participate in one or more of the utilization review program's health care professional networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

(5) not have been directly involved in making the adverse determination; and

(6) consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the utilization review program by the enrollee's health care professional or health care provider and any medical literature provided to the utilization review program by the health care professional or health care provider.

Section 55. Limitation on prior authorization. A utilization review program shall not require prior authorization:

(1) where a medication or procedure prescribed for a patient is customary and properly indicated or is a

treatment for the clinical indication as supported by peer-reviewed medical publications;

(2) for a patient currently managed with an established treatment regimen; or

(3) for the provision of medication-assisted treatment for the treatment of substance use disorder as those terms are defined in the Substance Use Disorder Act.

Section 60. Denial.

(a) The utilization review program may not revoke, limit, condition, or restrict a prior authorization.

(b) Notwithstanding any other provision of law, a utilization review program shall approve claims and payment shall be made on claims for health care services for which prior authorization was required and received prior to the rendering of health care services, unless one of the following occurs:

(1) it is timely determined that the enrollee's health care professional or health care provider knowingly provided health care services that required prior authorization from the utilization review program without first obtaining prior authorization for those health care services;

(2) it is timely determined that the health care services claimed were not performed;

(3) it is timely determined that the health care

services rendered were contrary to the instructions of the utilization review program or its delegated physician reviewer if contact was made between those parties prior to the service being rendered;

(4) it is timely determined that the enrollee receiving such health care services was not an enrollee of the health care plan; or

(5) the authorization was based upon a material misrepresentation by the enrollee or health care provider; as used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

Section 65. Length of prior authorization. A prior authorization shall be valid for 15 months after the date the health care professional or health care provider receives the prior authorization and the authorization period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional.

Section 70. Length of prior authorization for treatment for chronic or long-term care conditions. If a utilization review program requires a prior authorization for a health care service for the treatment of a chronic or long-term care

condition, the prior authorization shall remain valid for the length of the treatment as determined by the patient's health care professional and the utilization review program may not require the enrollee to obtain a prior authorization again for the health care service.

Section 75. Continuity of care for enrollees.

(a) On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care professional or health care provider, a utilization review program shall honor a prior authorization granted to an enrollee from a previous utilization review program for at least the initial 90 days of an enrollee's coverage under a new health plan.

(b) During the time period described in subsection (a), a utilization review program may perform its own review to grant a prior authorization.

(c) If there is a change in coverage of or approval criteria for a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.

(d) A utilization review program shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance

company.

Section 80. Health care services deemed authorized if a utilization review program fails to comply with the requirements of this Act. Any failure by a utilization review program to comply with the deadlines and other requirements specified in this Act shall result in any health care services subject to review to be automatically deemed authorized by the utilization review program.

Section 85. Severability. If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

Section 90. Administration and enforcement.

(a) The Department shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law. To enforce the provisions of this Act, the Director is hereby granted specific authority to issue a cease and desist order or require a utilization review program or insurer to submit a plan of correction for violations of this Act, or both. Subject to the provisions of the Illinois Administrative Procedure Act, the Director may, pursuant to Section 403A of the Illinois

Insurance Code, impose upon a utilization review program or insurer an administrative fine not to exceed $250,000 for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this Act.

(b) Any person who believes that his or her utilization review program or insurer is in violation of the provisions of this Act may file a complaint with the Department. The Department shall review all complaints received and investigate all of those complaints that it deems to state a potential violation. The Department shall fairly, efficiently, and timely review and investigate complaints. Utilization review programs found to be in violation of this Act shall be penalized in accordance with this Section.

(c) The Department of Healthcare and Family Services shall enforce the provisions of this Act as it applies to persons enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act.

Section 900. The Managed Care Reform and Patient Rights Act is amended by changing Sections 45.2 and 70 as follows:

(215 ILCS 134/45.2)

Sec. 45.2. Prior authorization form; prescription benefits.

(a) Notwithstanding any other provision of law, ~~on and~~

~~after January 1, 2015,~~ a health insurer that provides prescription drug benefits must comply with the requirements of the Prior Authorization Reform Act~~, within 72 hours after receipt of a paper or electronic prior authorization form from a prescribing provider or pharmacist, either approve or deny the prior authorization. In the case of a denial, the insurer shall provide the prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the denial~~.

~~In the case of an expedited coverage determination, the health insurer must either approve or deny the prior authorization within 24 hours after receipt of the paper or electronic prior authorization form. In the case of a denial, the health insurer shall provide the prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.~~

(b) This Section does not apply to plans for beneficiaries of Medicare or Medicaid.

(c) For the purposes of this Section:

"Pharmacist" has the same meaning as set forth in the Pharmacy Practice Act.

"Prescribing provider" includes a provider authorized to write a prescription, as described in subsection (e) of Section 3 of the Pharmacy Practice Act, to treat a medical condition of an insured.

(Source: P.A. 98-1035, eff. 8-25-14.)

(215 ILCS 134/70)

Sec. 70. Post-stabilization medical services.

~~(a)~~ If prior authorization for covered post-stabilization services is required by the health care plan, the plan shall comply with the requirements of the Prior Authorization Reform Act ~~provide access 24 hours a day, 7 days a week to persons designated by the plan to make such determinations, provided that any determination made under this Section must be made by a health care professional. The review shall be resolved in accordance with the provisions of Section 85 and the time requirements of this Section~~.

~~(b) The treating physician licensed to practice medicine in all its branches or health care provider shall contact the health care plan or delegated health care provider as designated on the enrollee's health insurance card to obtain authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee.~~

~~(c) The treating physician licensed to practice medicine in all its branches or health care provider shall document in the enrollee's medical record the enrollee's presenting symptoms; emergency medical condition; and time, phone number dialed, and result of the communication for request for authorization of post-stabilization medical services. The health care plan shall provide reimbursement for covered post stabilization~~

~~medical services if:~~

~~(1) authorization to render them is received from the health care plan or its delegated health care provider, or~~

~~(2) after 2 documented good faith efforts, the treating health care provider has attempted to contact the enrollee's health care plan or its delegated health care provider, as designated on the enrollee's health insurance card, for prior authorization of post stabilization medical services and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request. "Two documented good faith efforts" means the health care provider has called the telephone number on the enrollee's health insurance card or other available number either 2 times or one time and an additional call to any referral number provided. "Good faith" means honesty of purpose, freedom from intention to defraud, and being faithful to one's duty or obligation. For the purpose of this Act, good faith shall be presumed.~~

~~(d) After rendering any post-stabilization medical services, the treating physician licensed to practice medicine in all its branches or health care provider shall continue to make every reasonable effort to contact the health care plan or its delegated health care provider regarding authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee until the treating health care~~

~~provider receives instructions from the health care plan or delegated health care provider for continued care or the care is transferred to another health care provider or the patient is discharged.~~

~~(c) Payment for covered post stabilization services may be denied:~~

~~(1) if the treating health care provider does not meet the conditions outlined in subsection (c);~~

~~(2) upon determination that the post stabilization services claimed were not performed;~~

~~(3) upon timely determination that the post-stabilization services rendered were contrary to the instructions of the health care plan or its delegated health care provider if contact was made between those parties prior to the service being rendered;~~

~~(4) upon determination that the patient receiving such services was not an enrollee of the health care plan; or~~

~~(5) upon material misrepresentation by the enrollee or health care provider; "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.~~

~~(f) Nothing in this Section prohibits a health care plan from delegating tasks associated with the responsibilities enumerated in this Section to the health care plan's contracted health care providers or another entity. Only a clinical peer may make an adverse determination. However, the ultimate~~

~~responsibility for coverage and payment decisions may not be delegated.~~

~~(g) Coverage and payment for post-stabilization medical services for which prior authorization or deemed approval is received shall not be retrospectively denied.~~

~~(h) Nothing in this Section shall prohibit the imposition of deductibles, copayments, and co-insurance. Nothing in this Section alters the prohibition on billing enrollees contained in the Health Maintenance Organization Act.~~

(Source: P.A. 91-617, eff. 1-1-00.)

Section 905. The Illinois Public Aid Code is amended by adding Section 5-5.12d as follows:

(305 ILCS 5/5-5.12d new)

Sec. 5-5.12d. Managed care organization prior authorization of health care services.

(a) As used in this Section, "health care service" has the meaning given to that term in the Prior Authorization Reform Act.

(b) Notwithstanding any other provision of law to the contrary, all managed care organizations shall comply with the requirements of the Prior Authorization Reform Act.

Section 999. Effective date. This Act takes effect January 1, 2021.