A BILL FOR AN ACT

CONCERNING ALTERNATIVES TO HEALTH INSURER PRIOR AUTHORIZATION REQUIREMENTS FOR HEALTH-CARE PROVIDERS THAT ACHIEVE A SPECIFIED APPROVAL RATE ON PRIOR AUTHORIZATION REQUESTS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

With regard to health-care services, section 1 of the bill requires a health insurance carrier (carrier) or private utilization review organization, as applicable, to offer a provider with at least a 95%
approval rate of prior authorization requests over the prior 12 months an alternative to prior authorization requirements, including an exemption from the requirements, incentive awards, or other innovative programs, to reward provider compliance.

With regard to drug benefits, section 2 requires a carrier or pharmacy benefit management firm, as applicable, to offer the same types of alternatives to prior authorization requirements to a provider who has at least a 95% approval rate of prior authorization requests over the prior 12 months.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 10-16-112.5, amend (7)(e); and add (4)(b)(II)(C) and (4)(c) as follows:

10-16-112.5. Prior authorization for health-care services - disclosures and notice - determination deadlines - criteria - limits and exceptions - definitions - rules - repeal. (4) Criteria, limits, and exceptions. (b) (II) (C) This subsection (4)(b)(II) is repealed, effective January 1, 2024.

(c) (I) On and after January 1, 2024, a carrier or organization shall offer a qualified provider at least one alternative to prior authorization, including:

(A) An exemption from prior authorization requirements;

(B) An incentive awarded to the provider that reduces the wait time for or administrative burden on a covered person to receive the requested health-care service; or

(C) Any other innovative program of the carrier's or organization's design to reward provider compliance with the carrier's or organization's prior authorization requirements and that reduces the wait time for or administrative burden on a covered person to receive the requested health-care service.
(II) A PROVIDER IS A QUALIFIED PROVIDER FOR PURPOSES OF SUBSECTION (4)(c)(I) OF THIS SECTION IF THE PROVIDER:

(A) IS A PARTICIPATING PROVIDER AND HAS BEEN A PARTICIPATING PROVIDER CONTINUOUSLY FOR AT LEAST THE IMMEDIATELY PRECEDING TWELVE MONTHS; AND

(B) OVER THE IMMEDIATELY PRECEDING TWELVE MONTHS, HAS:

AT LEAST A NINETY-FIVE PERCENT APPROVAL RATE ON PRIOR AUTHORIZATION REQUESTS FOR THE SAME HEALTH-CARE SERVICE SUBMITTED FOR COVERED PERSONS UNDER A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER; AND SUBMITTED AT LEAST TWENTY-FOUR PRIOR AUTHORIZATION REQUESTS FOR THE SAME HEALTH-CARE SERVICE FOR COVERED PERSONS UNDER A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER.

(III) NEITHER A CARRIER NOR AN ORGANIZATION IS REQUIRED TO OFFER AN ALTERNATIVE TO PRIOR AUTHORIZATION TO A PROVIDER THAT IS NOT QUALIFIED PURSUANT TO SUBSECTION (4)(c)(II) OF THIS SECTION, INCLUDING A PROVIDER THAT HAS NOT SUBMITTED PRIOR AUTHORIZATION REQUESTS TO THE CARRIER OR ORGANIZATION FOR AT LEAST TWELVE MONTHS.

(IV) AT LEAST ANNUALLY, A CARRIER OR ORGANIZATION SHALL REEXAMINE A PROVIDER'S PRESCRIBING OR ORDERING PATTERNS AND REEVALUATE WHETHER THE PROVIDER IS A QUALIFIED PROVIDER FOR PURPOSES OF AN EXEMPTION FROM OR OTHER ALTERNATIVE TO PRIOR AUTHORIZATION REQUIREMENTS PURSUANT TO SUBSECTION (4)(c)(I) OF THIS SECTION.

(V) THE CARRIER OR ORGANIZATION SHALL INFORM THE PROVIDER OF THE PROVIDER'S STATUS AS A QUALIFIED PROVIDER AND PROVIDE ALL
OF THE DATA CONSIDERED AS PART OF ITS INITIAL EXAMINATION OR REEXAMINATION OF THE PROVIDER'S PRESCRIBING OR ORDERING PATTERNS FOR THE TWELVE-MONTH PERIOD OF REVIEW. DISAGREEMENTS REGARDING A PROVIDER'S STATUS AS A QUALIFIED PROVIDER MUST BE RESOLVED IN ACCORDANCE WITH ANY APPLICABLE CONTRACT PROVISIONS.

(VI) AS USED IN SUBSECTION (4)(c)(II)(B) OF THIS SECTION, "SAME HEALTH-CARE SERVICE" MEANS A HEALTH-CARE SERVICE THAT IS ASSIGNED A UNIQUE CPT CODE OR COMBINATION OF CPT CODES, AS DEFINED IN SECTION 25-49-102 (2), WHICH CODE OR COMBINATION OF CODES IS USED FOR THE CARE OF A PATIENT WITH A SPECIFIC DIAGNOSIS.

(7) Definitions. As used in this section:

(e) "Private utilization review organization" or "organization" has the same meaning as set forth MEANS A PRIVATE UTILIZATION REVIEW ORGANIZATION, AS DEFINED in section 10-16-112 (1)(a), THAT HAS A CONTRACT WITH AND PERFORMS PRIOR AUTHORIZATION ON BEHALF OF A CARRIER.

SECTION 2. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.