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Insights

Legislation Streamlining Prior Authorization Requirements for Commercial Health Insurance Plans Becomes Law

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On March 14, 2018, Governor Eric J. Holcomb signed into law a measure that provides for significant streamlining of the prior authorization requirements for health care services covered by commercial health insurance plans in Indiana that are not otherwise governed by ERISA. House Enrolled Act 1143 ("HEA 1143"), authored by Representative Donna Schaibley and sponsored by Senator Liz Brown, was a priority for numerous patient and provider groups during the 2018 legislative session and passed the legislature almost unanimously before making its way to Governor Holcomb's desk.

The prior authorization provisions contained in HEA 1143 are applicable to policies of accident and sickness insurance; contracts with health maintenance organizations that provide coverage for basic health care services; and self-insurance programs for state employees. The provisions of HEA 1143 do not apply to the following: (1) Dental services. (2) Vision services. (3) Long term rehabilitation treatment. (4) Pharmaceutical services or products. (5) Group health plans that are offered by local units of government. (6) Step therapy protocol exception procedures.

Under HEA 1143, effective September 1, 2018, health insurance plans are required to make public on their respective websites the CPT codes for which prior authorization is required, as well as a list of the health insurance plans' prior authorization requirements. The prior authorization requirements shall include the specific information that a provider must submit to establish a complete request for prior authorization. While a health insurance plan may require additional information upon review of the request for prior authorization, any changes to the actual standards of a health insurance plan's prior authorization requirements must be made public 45 days' prior to the change.

Also notable, effective January 1, 2020, prior authorization determinations will be required to be made within 72 hours for urgent care situations, and within seven (7) business days for non-urgent care situations. If a request is denied, the health insurance plan shall provide the specific reason for the denial within the applicable timeframe.

Further, health insurance plans will be required to accept prior authorization requests from providers through secure electronic transmissions, and shall acknowledge receipt of the electronic transmissions through the use of a transaction number or other reference code. However, a health insurance plan may not require the use of secure electronic transmissions for prior authorization requests if electronic transmissions would cause a health care provider financial hardship or the area in which the health care provider is located lacks sufficient Internet access.

Finally, also effective January 1, 2020, HEA 1143 provides that a health plan may not deny payment for services that have otherwise received prior authorization, unless the prior authorization request or the claim contained fraudulent or materially incorrect information, or the covered individual was not covered under the health insurance plan on the date on which the health care service was rendered. If a claim contains an unintentional and inaccurate inconsistency with the request for prior authorization, though, the health care provider may resubmit the claim with accurate, corrected information.

If you have any questions regarding HEA 1143 or this alert, please contact Amy M. Levander at alevander@kdlegal.com or your regular Krieg DeVault attorney.