HB 618 -- PRIOR AUTHORIZATION OF HEALTH CARE SERVICES (Stinnett)

COMMITTEE OF ORIGIN: Standing Committee on Insurance

This bill provides that a health carrier or utilization review entity cannot require health care providers to obtain prior authorization for health care services, except under certain circumstances.

Beginning January 1, 2026, prior authorization is not required unless a determination is made that less than 90% of prior authorization requests submitted by the health care provider in the previous evaluation period, as defined in the bill, were or would have been approved.

The bill establishes separate thresholds for requiring prior authorization for individual health care services or requiring prior authorization for all health care services.

Hospitals must meet one of three conditions for exemption:

(1) Enter into a value-based care agreement;

(2) Achieve a score of three or higher on the Center for Medicare and Medicaid Services Five-Star Quality Rating System; or

(3) Have at least 91% of prior authorization requests approved.

Critical access hospitals and those not participating in the Center for Medicare and Medicaid Services Five-Star system are automatically exempt from these conditions.

Exemptions may be audited, up to a maximum of two times per year, and revoked under specific conditions, such as approval rates dropping below 90% or a significant increase in exempt procedures. Additionally, exemptions are void if providers are found guilty of fraud or abuse.

The exemption from prior authorization requirements will not include:

(1) Pharmacy services, not to exceed the amount of $100,000;

(2) Imaging services, not to exceed the amount of $100,000;

(3) Cosmetic procedures that are not medically necessary; or

(4) Investigative or experimental treatments.

The amounts for the pharmacy services and imaging services listed above will increased every year, rounded to the nearest thousand dollars, beginning January 1, 2027, based on the Consumer Price Index.

Online portals may be required for prior authorization submissions. Patients with a new health plan receive a 90-day grace period for previously authorized medications.

The bill specifies requirements for notifying the provider of determinations in the bill, requires carriers and utilization review entities to maintain an online portal giving providers access to certain information, and provides that prior authorizations may be required beginning 25 business days after notice to the provider until the end of the evaluation period. Failure to notify providers of a determination as required in the bill will constitute prior authorization of the applicable health care services.

Lastly, no health carrier or utilization review entity can deny or reduce payments to a health care provider who had a prior authorization, unless the provider made a knowing and material misrepresentation with the intent to deceive the carrier or utilization review entity, or unless the health care service was not substantially performed.

This bill will not apply to Medicaid, except with regard to a Medicaid managed care organization as defined by law. The bill also does not apply to providers who have not participated in a health benefit plan offered by the carrier for at least one full evaluation period.

This bill should not be construed to authorize providers to provide services outside the scope of their licenses, nor to require health carriers or utilization review entities to pay for care provided outside the scope of a provider's license.