

REFERENCE TITLE: health insurance; prescriptions; prior authorization

State of Arizona
Senate
Fifty-first Legislature
Second Regular Session
2014

SB 1361

Introduced by
Senators Ward, Bradley, Hobbs; Representatives Larkin, Steele; Senators
Farley, McComish, Tovar; Representatives Boyer, Cardenas, Carter,
Livingston

AN ACT

AMENDING TITLE 20, CHAPTER 1, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 5;
AMENDING SECTION 36-2906, ARIZONA REVISED STATUTES; RELATING TO PRIOR
AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Title 20, chapter 1, Arizona Revised Statutes, is amended
3 by adding article 5, to read:

4 ARTICLE 5. PRIOR AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS
5 20-195. Electronic prior authorization; prescription drugs;
6 health care insurers; rules; definitions

7 A. BEGINNING JANUARY 1, 2016, A HEALTH CARE INSURER THAT PROVIDES
8 PRESCRIPTION DRUG BENEFITS SHALL USE THE PRIOR AUTHORIZATION PROCESS
9 ESTABLISHED PURSUANT TO SUBSECTION C OF THIS SECTION WHEN REQUIRING PRIOR
10 AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS.

11 B. A HEALTH CARE PROFESSIONAL MAY INITIATE THE PRIOR AUTHORIZATION
12 REQUEST WITH A HEALTH CARE INSURER AND THE HEALTH CARE PROFESSIONAL OR THE
13 AUTHORIZED AGENT OF THE HEALTH CARE PROFESSIONAL MAY CONFER AND CONSULT WITH
14 A HEALTH CARE INSURER REGARDING A PRIOR AUTHORIZATION REQUEST.

15 C. ON OR BEFORE JULY 1, 2015, THE DIRECTOR, BY RULE, SHALL:

16 1. PRESCRIBE A SINGLE, STANDARD FORM FOR REQUESTING PRIOR
17 AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS.

18 2. REQUIRE A HEALTH CARE INSURER OR THE AGENT OF A HEALTH CARE INSURER
19 TO USE THE FORM FOR ANY PRIOR AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS
20 REQUIRED BY THE HEALTH CARE INSURER.

21 3. REQUIRE A HEALTH CARE INSURER OR THE AGENT OF A HEALTH CARE INSURER
22 TO MAKE AVAILABLE AND ACCESSIBLE IN A CENTRALIZED LOCATION ON ITS WEBSITE ITS
23 PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, INCLUDING A LIST OF
24 PRESCRIPTION DRUGS THAT REQUIRE PRIOR AUTHORIZATION.

25 4. REQUIRE THAT THE HEALTH CARE INSURER MAKE THE FORM AVAILABLE
26 ELECTRONICALLY AND ALLOW A COMPLETED FORM TO BE SUBMITTED ELECTRONICALLY BY
27 THE HEALTH CARE PROFESSIONAL.

28 D. BEGINNING JANUARY 1, 2016, A PRIOR AUTHORIZATION REQUEST IS DEEMED
29 GRANTED IF A HEALTH CARE INSURER FAILS TO:

30 1. USE THE PRIOR AUTHORIZATION PROCESS PRESCRIBED IN RULE BY THE
31 DIRECTOR.

32 2. FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED ELECTRONICALLY:

33 (a) NOTIFY THE HEALTH CARE PROFESSIONAL WITHIN TWO BUSINESS DAYS AFTER
34 RECEIPT OF THE REQUEST THAT THE REQUEST IS APPROVED, DENIED OR INCOMPLETE,
35 AND, IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL INFORMATION THAT IS
36 REQUIRED TO PROCESS THE REQUEST.

37 (b) NOTIFY THE HEALTH CARE PROFESSIONAL WITHIN TWO BUSINESS DAYS AFTER
38 RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE HEALTH CARE INSURER THAT
39 THE REQUEST IS APPROVED OR DENIED.

40 3. FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED BY FAX OR E-MAIL:

41 (a) NOTIFY THE HEALTH CARE PROFESSIONAL WITHIN THREE BUSINESS DAYS
42 AFTER RECEIVING THE REQUEST THAT THE REQUEST IS APPROVED, DENIED OR
43 INCOMPLETE, AND, IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL INFORMATION
44 THAT IS REQUIRED TO PROCESS THE REQUEST.

1 (b) NOTIFY THE HEALTH CARE PROFESSIONAL WITHIN THREE BUSINESS DAYS
2 AFTER RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE HEALTH CARE
3 INSURER THAT THE REQUEST IS APPROVED OR DENIED.

4 4. FOR URGENT PRIOR AUTHORIZATION REQUESTS, NOTIFY THE HEALTH CARE
5 PROFESSIONAL WITHIN ONE DAY AFTER THE RECEIPT OF THE REQUEST THAT THE REQUEST
6 IS APPROVED OR DENIED.

7 E. FOR THE PURPOSES OF THIS SECTION:

8 1. "AUTHORIZED AGENT OF THE HEALTH CARE PROFESSIONAL" MEANS:

9 (a) AN EMPLOYEE OF THE HEALTH CARE PROFESSIONAL.

10 (b) A CONTRACT EMPLOYEE OF THE HEALTH CARE PROFESSIONAL.

11 2. "ELECTRONICALLY":

12 (a) MEANS THE SUBMISSION OF A PRIOR AUTHORIZATION REQUEST TO A HEALTH
13 CARE INSURER THROUGH A SECURE, WEB-BASED INTERNET PORTAL.

14 (b) DOES NOT INCLUDE THE SUBMISSION OF A PRIOR AUTHORIZATION REQUEST
15 BY E-MAIL.

16 3. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY
17 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,
18 HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL AND
19 MEDICAL SERVICE CORPORATION.

20 4. "HEALTH CARE PROFESSIONAL" MEANS A HEALTH CARE PROFESSIONAL WHO IS
21 LICENSED OR CERTIFIED UNDER TITLE 32 AND WHO IS AUTHORIZED TO PRESCRIBE
22 PRESCRIPTION DRUGS.

23 5. "URGENT PRIOR AUTHORIZATION REQUEST" MEANS A PRIOR AUTHORIZATION
24 REQUEST OF A DRUG BENEFIT THAT, BASED ON THE REASONABLE OPINION OF THE HEALTH
25 CARE PROFESSIONAL WITH KNOWLEDGE OF THE COVERED PERSON'S MEDICAL CONDITION,
26 IF DETERMINED IN THE TIME ALLOWED FOR NONURGENT PRIOR AUTHORIZATION REQUESTS,
27 COULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR THE
28 ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM FUNCTION OR SUBJECT THE
29 COVERED PERSON TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE
30 DRUG BENEFIT THAT IS THE SUBJECT OF THE PRIOR AUTHORIZATION REQUEST.

31 Sec. 2. Section 36-2906, Arizona Revised Statutes, is amended to read:

32 36-2906. Qualified plan health services contracts; proposals;
33 administration

34 A. The administration shall:

35 1. Supervise the administrator.

36 2. Review the proposals.

37 3. Award contracts.

38 B. The director shall prepare and issue a request for proposal,
39 including a proposed contract format, in each of the counties of this state,
40 at least once every five years, to qualified group disability insurers,
41 hospital and medical service corporations, health care services organizations
42 and any other qualified public or private persons, including county-owned and
43 operated health care facilities. The contracts shall specify the
44 administrative requirements, the delivery of medically necessary services and
45 the subcontracting requirements.

1 C. The director shall adopt rules regarding the request for proposal
2 process that provide:

3 1. For definition of proposals in the following categories subject to
4 the following conditions:

5 (a) Inpatient hospital services.

6 (b) Outpatient services, including emergency dental care, and early
7 and periodic health screening and diagnostic services for children.

8 (c) Pharmacy services.

9 (d) Laboratory, x-ray and related diagnostic medical services and
10 appliances.

11 2. Allowance for the adjustment of such categories by expansion,
12 deletion, segregation or combination in order to secure the most financially
13 advantageous proposals for the system.

14 3. An allowance for limitations on the number of high risk persons
15 that must be included in any proposal.

16 4. For analysis of the proposals for each geographic service area as
17 defined by the director to ensure the provision of health and medical
18 services that are required to be provided throughout the geographic service
19 area pursuant to section 36-2907.

20 5. For the submittal of proposals by a group disability insurer, A
21 hospital and medical service corporation, A health care services organization
22 or any other qualified public or private person intending to submit a
23 proposal pursuant to this section. Each qualified proposal shall be entered
24 with separate categories for the distinct groups of persons to be covered by
25 the proposed contracts, as set forth in the request for proposal.

26 6. For the procurement of reinsurance for expenses incurred by any
27 contractor or member or the system in providing services in excess of amounts
28 specified by the director in any contract year. The director shall adopt
29 rules to provide that the administrator may specify guidelines on a case by
30 case basis for the types of care and services that may be provided to a
31 person whose care is covered by reinsurance. The rules shall provide that if
32 a contractor does not follow specified guidelines for care or services and if
33 the care or services could be provided pursuant to the guidelines at a lower
34 cost the contractor is entitled to reimbursement as if the care or services
35 specified in the guidelines had been provided.

36 7. For the awarding of contracts to contractors with qualified
37 proposals determined to be the most advantageous to the state for each of the
38 counties in this state. A contract may be awarded that provides services
39 only to persons defined as eligible pursuant to section 36-2901, paragraph 6,
40 subdivision (b), (c), (d) or (e). The director may provide by rule a second
41 round competitive proposal procedure for the director to request voluntary
42 price reduction of proposals from only those that have been tentatively
43 selected for award, before the final award or rejection of proposals.

44 8. For the requirement that any proposal in a geographic service area
45 provide for the full range of system covered services.

- 1 1. The director of the department of insurance or the director's
2 designee.
- 3 2. Three members who are representatives of different health care
4 insurers as defined in section 20-195, Arizona Revised Statutes, as added by
5 this act, and who are appointed by the director of the department of
6 insurance.
- 7 3. Three members who are representatives of different health care
8 professionals licensed or certified under title 32, Arizona Revised Statutes,
9 who are authorized to prescribe prescription drugs and who are appointed by
10 the director of the department of insurance.
- 11 4. One member who is a pharmacist licensed under title 32, Arizona
12 Revised Statutes, and who is appointed by the director of the department of
13 insurance.
- 14 5. One member of the public who is appointed by the director of the
15 department of insurance.
- 16 6. The director of the Arizona health care cost containment system or
17 the director's designee.
- 18 7. One member of an organization that represents patients with chronic
19 health conditions who is appointed by the director of the department of
20 insurance.
- 21 B. Committee members shall serve at the pleasure of the director of
22 the department of insurance and are not eligible to receive compensation or
23 reimbursement for expenses.
- 24 C. On or before January 1, 2015, the committee shall advise the
25 director of the department of insurance on the technical, operational and
26 practical aspects of developing a standard authorization form for requesting
27 prior authorization of prescription drug benefits by developing
28 recommendations regarding a standard uniform prior authorization form and an
29 electronic submission process for prescription drugs to simplify the prior
30 authorization process. The director shall incorporate these recommendations
31 in the rules adopted pursuant to section 20-195, Arizona Revised Statutes, as
32 added by this act. The recommended prior authorization form must be designed
33 to permit its use as a written document and to be electronically available
34 and transmissible.
- 35 D. In developing the recommendations regarding a standard uniform
36 prior authorization form the committee must consider:
 - 37 1. Any form for requesting prior authorization widely used in this
38 state.
 - 39 2. Any form for requesting prior authorization developed by another
40 state.
 - 41 3. Forms for the prior authorization of benefits established by the
42 federal centers for medicare and medicaid services.
 - 43 4. National standards pertaining to the electronic prior authorization
44 of benefits.

1 5. Public comment from interested parties pursuant to at least one
2 public meeting conducted by the committee.
3 E. This section is repealed from and after June 30, 2015.
4 Sec. 4. Department of insurance; rulemaking exemption
5 For the purposes of implementing section 20-195, Arizona Revised
6 Statutes, as added by this act, the department of insurance is exempt from
7 the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes,
8 until July 1, 2015, except that the department shall provide public notice
9 and an opportunity for public comment on proposed rules at least thirty days
10 before a rule is adopted or amended.