REFERENCE TITLE: utilization review; prior authorization; requirements

State of Arizona
Senate
Fifty-seventh Legislature
First Regular Session
2025

SB 1512

Introduced by
Senator Payne

AN ACT

AMENDING TITLE 20, CHAPTER 15, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2512; RELATING TO UTILIZATION REVIEW.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 20, chapter 15, article 1, Arizona Revised Statutes, is amended by adding section 20-2512, to read:

20-2512. Utilization review; prior authorization requirements; definitions

A. IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT APPROVES A PRIOR AUTHORIZATION FOR A COVERED SERVICE TO A MEMBER AND THAT MEMBER CHANGES HEALTH INSURANCE, THE NEW HEALTH CARE INSURER SHALL HONOR THE PRIOR AUTHORIZATION FOR THE FIRST NINETY DAYS OF THE MEMBER'S HEALTH INSURANCE COVERAGE UNLESS THE SERVICE IS CATEGORICALLY EXCLUDED FROM COVERAGE UNDER THE MEMBER'S NEW HEALTH INSURANCE PLAN. THE MEMBER OR THE MEMBER'S PREVIOUS PROVIDER SHALL NOTIFY THE NEW HEALTH CARE INSURER OF THE PREVIOUSLY GRANTED PRIOR AUTHORIZATION.

B. DURING THE NINETY-DAY PERIOD PRESCRIBED IN SUBSECTION A OF THIS SECTION, A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT MAY CONDUCT A PRIOR AUTHORIZATION REVIEW.

C. IF THERE IS A CHANGE IN COVERAGE OR APPROVAL CRITERIA FOR A PREVIOUSLY AUTHORIZED MEDICAL SERVICE, THE CHANGE IN COVERAGE OR APPROVAL CRITERIA DOES NOT AFFECT THE MEMBER WHO RECEIVED A PRIOR AUTHORIZATION APPROVAL BEFORE THE EFFECTIVE DATE OF THE CHANGE IN COVERAGE OR APPROVAL CRITERIA FOR THE REMAINDER OF THE MEMBER'S PLAN YEAR.

D. A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL CONTINUE TO HONOR A PRIOR AUTHORIZATION THAT THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT GRANTED TO A MEMBER WHEN THE MEMBER CHANGES PRODUCTS OR PLANS UNDER THE SAME HEALTH CARE INSURANCE COMPANY FOR NINETY DAYS.

E. A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL POST ON ITS PUBLICLY ACCESSIBLE WEBSITE ALL PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS AND A DETAILED DESCRIPTION OF THE CLINICAL CRITERIA WRITTEN IN LANGUAGE THAT IS UNDERSTANDABLE TO A LAY PERSON. IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT INTENDS TO IMPLEMENT A NEW PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION OR TO AMEND AN EXISTING PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION, THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL:

1. POST THE CHANGE OR AMENDMENT TO A PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION ON ITS PUBLICLY ACCESSIBLE WEBSITE BEFORE ENFORCING THE CHANGE OR AMENDMENT.

2. PROVIDE ENROLLEES WITH SIXTY DAYS' NOTICE BEFORE IMPLEMENTING THE NEW PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION OR AMENDING THE PRIOR AUTHORIZATION REQUIREMENT OR RESTRICTION.

F. EXCEPT AS PROVIDED IN SECTION 20-3405, IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT REQUIRES PRIOR AUTHORIZATION FOR A HEALTH CARE SERVICE TO TREAT A CHRONIC OR LONG-TERM CARE CONDITION, THE PRIOR AUTHORIZATION REMAINS VALID FOR AT LEAST ONE

YEAR FROM THE DATE THE HEALTH CARE SERVICE RECEIVES THE PRIOR AUTHORIZATION REGARDLESS OF ANY CHANGES IN DOSAGE OF A PRESCRIPTION DRUG, AND THE UTILIZATION REVIEW AGENT MAY NOT REQUIRE THAT THE MEMBER OBTAIN ANOTHER PRIOR AUTHORIZATION FOR THAT SAME HEALTH CARE SERVICE.

G. A PRIOR AUTHORIZATION IS VALID FOR AT LEAST SIX MONTHS FROM THE DATE THE HEALTH CARE INSURER RECEIVES THE PRIOR AUTHORIZATION OR THE LENGTH OF THE TREATMENT AND REMAINS IN EFFECT REGARDLESS OF ANY CHANGES IN THE PRESCRIPTION DOSAGE.

H. FOR THE PURPOSES OF THIS SECTION:

1. "CHRONIC OR LONG-TERM CARE CONDITION" MEANS A CONDITION THAT LASTS ONE YEAR OR MORE AND THAT REQUIRES ONGOING MEDICAL ATTENTION OR LIMITS ACTIVITIES OF DAILY LIVING OR BOTH.

2. "MEMBER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2530.