Consumer protection for prior authorization

DCBS | Consumer and Business Services

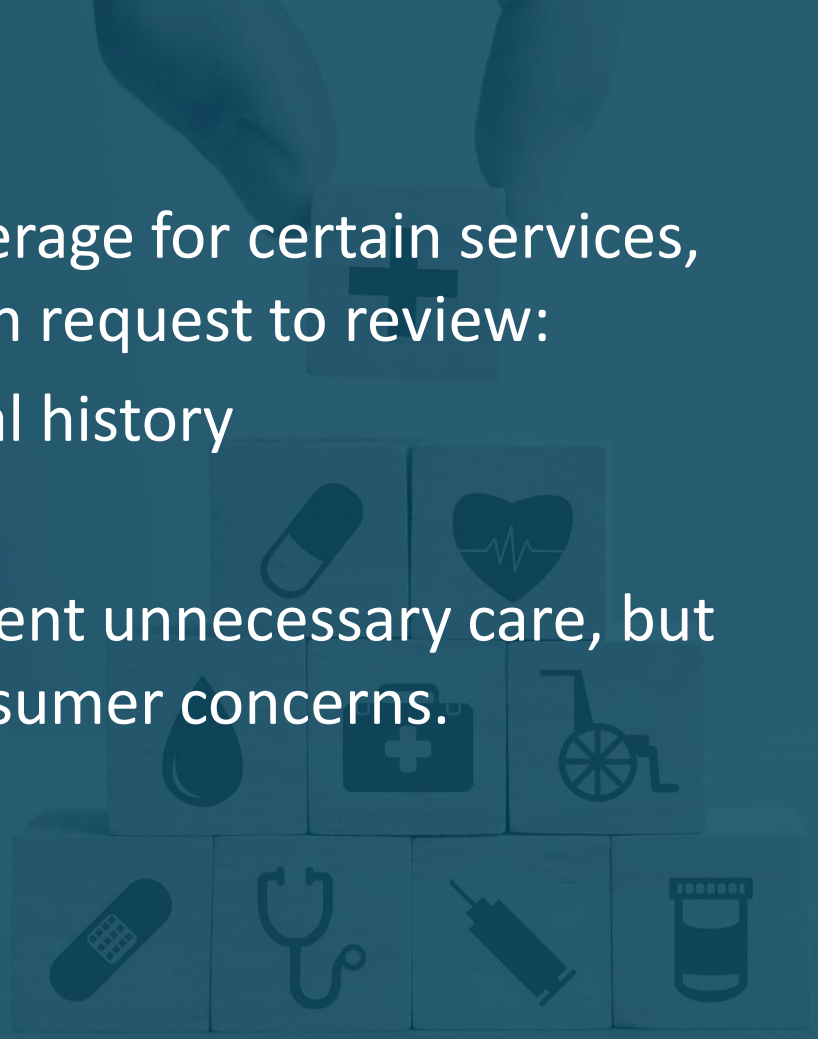
Division of Financial Regulation

Prior authorization -

Before approving or denying coverage for certain services, health insurance companies often request to review:

- Patient’s condition and medical history
- Evidence of medical necessity

This helps contain costs and prevent unnecessary care, but can also delay care and raise consumer concerns.



SB 249-A clarifies the timeline for handling prior authorizations:

- Requires a decision or request from more information be made within two business days
- “Answer” ≠ “Determination”
- When requesting more information:
  - Insurer can only make one request for additional information
  - Requires a decision within two business days of receiving new information
  - Requires a decision issued within 15 total days if new information is not received.

* A medical situation may require a faster decision

SB 249-A creates a transparent, efficient, and fair process for prior authorization requests by:

- Prohibiting insurers from misrepresenting facts
- Adopting standards for prompt review of requests
- Requiring insurers to act in good faith
- Clarifying a patient's right to appeal a decision to independent reviewers; and
- Clarifying who can make a request

Additional considerations

- SB 249-A is not intended to restrict prior authorizations
- SB 249-A is intended to provide a transparent, efficient, and fair prior authorization process for patients, insurers, and providers.
- SB 249-A works with existing process for a person to get an independent decision on whether a procedure should be authorized

Questions?