CHAPTER 333

INSURANCE

HOUSE BILL 24-1149

BY REPRESENTATIVE(S) Bird and Frizell, Amabile, Armagost, Bacon, Boesenecker, Bradfield, Clifford, deGruy Kennedy, Duran, English, Froelich, Garcia, Hamrick, Hartsook, Hernandez, Jodeh, Kipp, Lieder, Lindstedt, Mabrey, McLachlan, Ortiz, Rutinel, Sirota, Snyder, Soper, Taggart, Titone, Valdez, Velasco, Weinberg, Willford, Wilson, Young, Brown, Catlin, Lindsay, Marshall, Mauro, McCormick, Parenti, Weissman, McCluskie;
also SENATOR(S) Roberts and Kirkmeyer, Ginal, Baisley, Bridges, Buckner, Coleman, Cutter, Gonzales, Hansen, Hinrichsen, Kolker, Liston, Marchman, Michaelson Jenet, Mullica, Pelton R., Rich, Van Winkle, Will, Winter F., Zenzinger.

AN ACT

CONCERNING MODIFICATIONS TO REQUIREMENTS FOR PRIOR AUTHORIZATION OF BENEFITS UNDER HEALTH BENEFIT PLANS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Timely access to necessary health care is of vital importance to Coloradans;

(b) The provider-patient relationship is paramount and should not be subject to intrusion by a third party;

(c) Coloradans and their health-care providers deserve easy access to information regarding health insurance benefits so that, together, they can determine the proper course of treatment;

(d) Utilization management processes, such as prior authorization, delay care, which, according to thirty-four percent of physicians surveyed nationally, leads to serious adverse events for their patients, including hospitalization, permanent disability, or even death;

(e) These outcomes due to delays in timely accessing services and prescriptions are known to disproportionately impact historically marginalized populations, such as Black and Hispanic patients, furthering health disparities in the state;

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(f) Surveys have found that over sixty percent of physicians also report that it is difficult to determine whether a prescription medication or medical service requires prior authorization, adding burdensome administrative steps for health-care providers and patients to understand requirements for accessing necessary medical services or prescriptions; and

(g) Health systems spend an average of twenty dollars, for a primary care visit, to two hundred fifteen dollars, for an inpatient surgical procedure, on administrative tasks to navigate insurer utilization management processes like processing prior authorization requests.

(2) Therefore, it is the intent of the general assembly, by establishing transparent prescription formularies and enabling access to prior authorization requirements at the point of care delivery; requiring posting of data on prior authorization practices; and requiring carriers, private utilization review organizations, and pharmacy benefit managers to adopt a program that streamlines the administrative process for qualifying health-care providers who satisfy certain objective criteria regarding quality and appropriateness of care and specialty area and experience, to:

(a) Ensure Coloradans have equitable access to medically necessary care;

(b) Reduce administrative burdens and costs borne by health-care providers; and

(c) Reduce overall costs to the health-care system.

SECTION 2. In Colorado Revised Statutes, 10-16-112.5, **amend** (2)(a), (2)(c), (3)(a)(I), (3)(c)(II), (4)(b), (5)(a), (6), and (7)(e); and **add** (3)(c)(III), (3.5), and (4)(c) as follows:

10-16-112.5. Prior authorization for health-care services - disclosures and notice - determination deadlines - criteria - limits and exceptions - definitions - rules - enforcement. (2) **Disclosure of requirements - notice of changes.** (a) (I) A carrier shall ~~make~~ POST current prior authorization requirements and restrictions, including written, clinical criteria, ~~readily accessible~~ on the carrier's PUBLIC-FACING website IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE FORMAT. The prior authorization requirements must be described in detail and in clear and easily understandable language.

(II) If a carrier contracts with a private utilization review organization to perform prior authorization for health-care services, the organization shall provide its prior authorization requirements and restrictions, as required by this subsection (2), to the carrier with ~~whom~~ WHICH the organization contracted, and that carrier shall post the organization's prior authorization requirements and restrictions on its PUBLIC-FACING website IN THE MANNER REQUIRED BY SUBSECTION (2)(a)(I) OF THIS SECTION.

~~(III) When posting prior authorization requirements and restrictions pursuant to~~

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~~this subsection (2)(a) or subsection (2)(b) of this section, a carrier is neither required to post nor prohibited from posting the prior authorization requirements and restrictions on a public-facing portion of its website.~~

(c) (I) A carrier shall post, on a public-facing portion of its website, data regarding approvals and denials of prior authorization requests, including requests for drug benefits pursuant to section 10-16-124.5, in a readily accessible, STANDARDIZED, SEARCHABLE format and that include the following: ~~categories, in the aggregate:~~

(A) ~~Provider specialty~~ THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS RECEIVED IN THE IMMEDIATELY PRECEDING CALENDAR YEAR IN EACH OF THE FOLLOWING CATEGORIES OF SERVICES: MEDICAL PROCEDURES; DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES; PRESCRIPTION DRUGS; AND ALL OTHER CATEGORIES OF HEALTH-CARE SERVICES OR DRUG BENEFITS FOR WHICH A PRIOR AUTHORIZATION REQUEST WAS RECEIVED;

(B) ~~Medication or diagnostic test or procedure~~ THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE APPROVED IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION;

(B.5) THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS FOR WHICH AN ADVERSE DETERMINATION WAS ISSUED AND THE SERVICE WAS DENIED IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION;

(C) THE reason for THE denial IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION, WITH THE DENIAL REASONS SORTED BY CATEGORIES DEFINED BY RULE; and

(D) ~~Denials specified under subsection (2)(c)(I)(C) of this section that are overturned on appeal~~ IN EACH OF THE CATEGORIES SPECIFIED IN SUBSECTION (2)(c)(I)(A) OF THIS SECTION, THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE APPEALED AND WHETHER THE DETERMINATION WAS UPHELD OR REVERSED ON APPEAL.

(II) An organization OR PBM that provides prior authorization for a carrier shall provide the data specified in subsection (2)(c)(I) of this section to the carrier with ~~whom~~ WHICH the organization OR PBM contracted, and the carrier shall post the organization's OR PBM's data on its PUBLIC-FACING website IN THE MANNER REQUIRED BY SUBSECTION (2)(c)(I) OF THIS SECTION.

(III) Carriers and organizations shall use the data specified in this subsection (2)(c) to refine and improve their utilization management programs. CARRIERS AND ORGANIZATIONS SHALL REVIEW THE LIST OF MEDICAL PROCEDURES, DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES, PRESCRIPTION DRUGS, AND OTHER HEALTH-CARE SERVICES FOR WHICH THE CARRIER OR ORGANIZATION REQUIRES PRIOR

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AUTHORIZATION AT LEAST ANNUALLY AND SHALL ELIMINATE THE PRIOR AUTHORIZATION REQUIREMENTS FOR THOSE PROCEDURES, DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES, PRESCRIPTION DRUGS, OR OTHER HEALTH-CARE SERVICES FOR WHICH PRIOR AUTHORIZATION NEITHER PROMOTES HEALTH-CARE QUALITY OR EQUITY NOR SUBSTANTIALLY REDUCES HEALTH-CARE SPENDING. EACH CARRIER AND ORGANIZATION SHALL ANNUALLY ATTEST TO THE COMMISSIONER THAT IT HAS COMPLETED THE REVIEW REQUIRED BY THIS SUBSECTION (2)(c)(III) AND HAS ELIMINATED PRIOR AUTHORIZATION REQUIREMENTS CONSISTENT WITH THE REQUIREMENTS OF THIS SUBSECTION (2)(c)(III).

(IV) A CARRIER SHALL POST, ON A PUBLIC-FACING PORTION OF ITS WEBSITE, IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE FORMAT, DATA ON THE NUMBER OF EXEMPTIONS FROM PRIOR AUTHORIZATION REQUIREMENTS OR ALTERNATIVES TO PRIOR AUTHORIZATION REQUIREMENTS PROVIDED PURSUANT TO A PROGRAM ADOPTED BY THE CARRIER, ORGANIZATION, OR PBM PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION OR SECTION 10-16-124.5 (5.5), AS APPLICABLE. THE CARRIER SHALL INCLUDE THE FOLLOWING DATA:

(A) THE NUMBER OF PROVIDERS OFFERED AN EXEMPTION OR ALTERNATIVE PROGRAM, INCLUDING THEIR SPECIALTY AREAS;

(B) THE NUMBER AND CATEGORIZED TYPES OF EXEMPTIONS OR ALTERNATIVE PROGRAMS OFFERED TO PROVIDERS; AND

(C) THE PRESCRIPTION DRUG, DIAGNOSTIC TEST, PROCEDURE, OR OTHER HEALTH-CARE SERVICE FOR WHICH AN EXEMPTION OR ALTERNATIVE PROGRAM WAS OFFERED.

(V) THE COMMISSIONER SHALL ADOPT RULES TO:

(A) IMPLEMENT SUBSECTIONS (2)(c)(I) AND (2)(c)(IV) OF THIS SECTION TO ENSURE THAT THE DATA FIELDS REQUIRED TO BE POSTED PURSUANT TO SUBSECTIONS (2)(c)(I) AND (2)(c)(IV) OF THIS SECTION ARE PRESENTED CONSISTENTLY BY CARRIERS; AND

(B) DEFINE CATEGORIES OF PRIOR AUTHORIZATION REQUEST DENIALS FOR PURPOSES OF SUBSECTION (2)(c)(I)(C) OF THIS SECTION.

(3) **Nonurgent and urgent health-care services - timely determination - notice of determination - deemed approved.** (a) Except as provided in subsection (3)(b) of this section, a prior authorization request is deemed granted if a carrier or organization fails to:

(I) (A) Notify the provider and covered person, within five business days after receipt of the request, that the request is approved, denied, or incomplete and INDICATE: IF DENIED, WHAT RELEVANT ALTERNATIVE SERVICES OR TREATMENTS

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MAY BE A COVERED BENEFIT OR ARE REQUIRED BEFORE APPROVAL OF THE DENIED SERVICE OR TREATMENT; OR if incomplete, ~~indicate~~ the specific additional information, consistent with criteria posted pursuant to subsection (2)(a) of this section, that is required to process the request; or

(B) Notify the provider and covered person, within five business days after receiving the additional information required by the carrier or organization pursuant to subsection (3)(a)(I)(A) of this section, that the request is approved or denied AND, IF DENIED, INDICATE WHAT RELEVANT ALTERNATIVE SERVICES OR TREATMENTS MAY BE A COVERED BENEFIT OR ARE REQUIRED BEFORE APPROVAL OF THE DENIED SERVICE OR TREATMENT; and

(c) (II) If the carrier or organization denies a prior authorization request based on a ground specified in section 10-16-113 (3)(a), the notification is subject to the requirements of section 10-16-113 (3)(a) and commissioner rules adopted pursuant to that section and must:

(A) Include information concerning whether the carrier or organization requires an alternative treatment, test, procedure, or medication AND WHAT ALTERNATIVE SERVICES OR TREATMENTS WOULD BE APPROVED AS A COVERED BENEFIT UNDER THE HEALTH BENEFIT PLAN; OR

(B) IN THE CASE OF THE DENIAL OF A PRIOR AUTHORIZATION REQUEST FOR A PRESCRIPTION DRUG, SPECIFY WHICH PRESCRIPTION DRUGS AND DOSAGES IN THE SAME CLASS AS THE PRESCRIPTION DRUG FOR WHICH THE PRIOR AUTHORIZATION REQUEST WAS DENIED ARE COVERED PRESCRIPTION DRUGS UNDER THE HEALTH BENEFIT PLAN.

(III) A CARRIER'S, ORGANIZATION'S, OR PHARMACY BENEFIT MANAGER'S COMPLIANCE WITH SUBSECTION (3)(c)(II) OF THIS SECTION DOES NOT CONSTITUTE THE PRACTICE OF MEDICINE.

(3.5) (a) STARTING JANUARY 1, 2027, A CARRIER OR ORGANIZATION SHALL HAVE, MAINTAIN, AND USE A PRIOR AUTHORIZATION APPLICATION PROGRAMMING INTERFACE THAT AUTOMATES THE PRIOR AUTHORIZATION PROCESS TO ENABLE A PROVIDER TO:

(I) DETERMINE WHETHER PRIOR AUTHORIZATION IS REQUIRED FOR A HEALTH-CARE SERVICE;

(II) IDENTIFY PRIOR AUTHORIZATION INFORMATION AND DOCUMENTATION REQUIREMENTS; AND

(III) FACILITATE THE EXCHANGE OF PRIOR AUTHORIZATION REQUESTS AND DETERMINATIONS FROM THE PROVIDER'S ELECTRONIC HEALTH RECORDS OR PRACTICE MANAGEMENT SYSTEMS THROUGH SECURE ELECTRONIC TRANSMISSION.

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(b) A CARRIER'S OR ORGANIZATION'S APPLICATION PROGRAMMING INTERFACE MUST MEET THE MOST RECENT STANDARDS AND IMPLEMENTATION SPECIFICATIONS ADOPTED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AS SPECIFIED IN 45 CFR 170.215 (a).

(c) IF A PROVIDER SUBMITS A PRIOR AUTHORIZATION REQUEST THROUGH THE CARRIER'S OR ORGANIZATION'S APPLICATION PROGRAMMING INTERFACE, THE CARRIER OR ORGANIZATION SHALL ACCEPT AND RESPOND TO THE REQUEST THROUGH THE INTERFACE.

(4) **Criteria, limits, and exceptions.** (b) (I) Carriers and organizations shall consider limiting the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors and present opportunities for improvement in adherence to the carrier's or organization's prior authorization requirements.

(II) ~~(A)~~ NO LATER THAN JANUARY 1, 2026, a carrier or AN organization ~~may offer providers with a history of adherence to the carrier's or organization's prior authorization requirements at least one alternative to prior authorization, including an exemption from prior authorization requirements for a provider that has at least an eighty percent approval rate of prior authorization requests over the immediately preceding twelve months.~~ SHALL ADOPT A PROGRAM, DEVELOPED IN CONSULTATION WITH PROVIDERS PARTICIPATING WITH THE CARRIER, TO ELIMINATE OR SUBSTANTIALLY MODIFY PRIOR AUTHORIZATION REQUIREMENTS IN A MANNER THAT REMOVES THE ADMINISTRATIVE BURDEN FOR QUALIFIED PROVIDERS, AS DEFINED UNDER THE PROGRAM, AND THEIR PATIENTS FOR CERTAIN HEALTH-CARE SERVICES AND RELATED BENEFITS BASED ON ANY OF THE FOLLOWING:

(A) THE PERFORMANCE OF PROVIDERS WITH RESPECT TO ADHERENCE TO NATIONALLY RECOGNIZED, EVIDENCE-BASED MEDICAL GUIDELINES, APPROPRIATENESS, EFFICIENCY, AND OTHER QUALITY CRITERIA; AND

(B) PROVIDER SPECIALTY, EXPERIENCE, OR OTHER OBJECTIVE FACTORS; EXCEPT THAT ELIGIBILITY FOR THE PROGRAM MUST NOT BE LIMITED BY PROVIDER SPECIALTY.

(III) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION:

(A) MUST NOT REQUIRE QUALIFIED PROVIDERS TO REQUEST PARTICIPATION IN THE PROGRAM; AND

(B) MAY INCLUDE LIMITING THE USE OF PRIOR AUTHORIZATION TO PROVIDERS WHOSE PRESCRIBING OR ORDERING PATTERNS DIFFER SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS AFTER ADJUSTING FOR PATIENT MIX AND OTHER RELEVANT FACTORS AND IN ORDER TO PRESENT THOSE PROVIDERS WITH

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OPPORTUNITIES FOR IMPROVEMENT IN ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS.

(IV) At least annually, a carrier or AN organization shall:

(A) Reexamine a provider's prescribing or ordering patterns; ~~and~~

(B) Reevaluate the provider's status for exemption from ~~or other alternative to~~ prior authorization requirements OR FOR INCLUSION IN THE PROGRAM DEVELOPED pursuant to ~~this~~ subsection (4)(b)(II) OF THIS SECTION; AND

~~(B)~~ (C) ~~The carrier or organization shall inform~~ NOTIFY the provider of the provider's STATUS FOR exemption ~~status and provide information on the data considered as part of its reexamination of the provider's prescribing or ordering patterns for the twelve-month period of review~~ OR INCLUSION IN THE PROGRAM.

(V) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION MUST INCLUDE PROCEDURES FOR A PROVIDER TO REQUEST:

(A) AN EXPEDITED, INFORMAL RESOLUTION OF A CARRIER'S OR AN ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM; AND

(B) IF THE MATTER IS NOT RESOLVED THROUGH INFORMAL RESOLUTION, BINDING ARBITRATION AS SPECIFIED IN SUBSECTION (4)(b)(VI) OF THIS SECTION.

(VI) IF A PROVIDER REQUESTS BINDING ARBITRATION PURSUANT TO THE PROCEDURES A CARRIER OR AN ORGANIZATION DEVELOPS UNDER SUBSECTION (4)(b)(V)(B) OF THIS SECTION, THE FOLLOWING PROVISIONS GOVERN THE ARBITRATION PROCEDURE:

(A) THE PROVIDER AND CARRIER OR ORGANIZATION SHALL JOINTLY SELECT AN ARBITRATOR FROM THE LIST OF ARBITRATORS APPROVED PURSUANT TO SECTION 10-16-704 (15)(b). NEITHER THE PROVIDER NOR THE CARRIER OR ORGANIZATION IS REQUIRED TO NOTIFY THE DIVISION OF THE ARBITRATION OR OF THE SELECTED ARBITRATOR.

(B) THE SELECTED ARBITRATOR SHALL DETERMINE THE PROVIDER'S ELIGIBILITY TO PARTICIPATE IN THE CARRIER'S OR ORGANIZATION'S PROGRAM BASED ON THE PROGRAM CRITERIA DEVELOPED PURSUANT TO SUBSECTION (4)(b)(II) OF THIS SECTION;

(C) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR ACCEPTS THE MATTER, THE PROVIDER AND THE CARRIER OR ORGANIZATION SHALL SUBMIT TO THE ARBITRATOR WRITTEN MATERIALS IN SUPPORT OF THEIR RESPECTIVE POSITIONS;

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(D) THE ARBITRATOR MAY RENDER A DECISION BASED ON THE WRITTEN MATERIALS SUBMITTED PURSUANT TO SUBSECTION (4)(b)(VI)(C) OF THIS SECTION OR MAY SCHEDULE A HEARING, LASTING NOT LONGER THAN ONE DAY, FOR THE PROVIDER AND CARRIER OR ORGANIZATION TO PRESENT EVIDENCE;

(E) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR RECEIVES THE WRITTEN MATERIALS OR, IF A HEARING IS CONDUCTED, THE DATE OF THE HEARING, THE ARBITRATOR SHALL ISSUE A WRITTEN DECISION STATING WHETHER THE PROVIDER IS ELIGIBLE FOR THE PROGRAM; AND

(F) IF THE ARBITRATOR OVERTURNS THE CARRIER'S OR ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM, THE CARRIER OR ORGANIZATION SHALL PAY THE ARBITRATOR'S FEES AND COSTS, AND IF THE ARBITRATOR AFFIRMS THE CARRIER'S OR ORGANIZATION'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM, THE PROVIDER SHALL PAY THE ARBITRATOR'S FEES AND COSTS.

(c) (I) WHEN A CARRIER OR AN ORGANIZATION APPROVES A PRIOR AUTHORIZATION REQUEST FOR A SURGICAL PROCEDURE FOR WHICH PRIOR AUTHORIZATION IS REQUIRED, THE CARRIER OR ORGANIZATION SHALL NOT DENY A CLAIM FOR AN ADDITIONAL OR A RELATED HEALTH-CARE PROCEDURE IDENTIFIED DURING THE AUTHORIZED SURGICAL PROCEDURE IF:

(A) THE PROVIDER, WHILE PROVIDING THE APPROVED SURGICAL PROCEDURE TO TREAT THE COVERED PERSON, DETERMINES, IN ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE, THAT PROVIDING A RELATED HEALTH-CARE PROCEDURE, INSTEAD OF OR IN ADDITION TO THE APPROVED SURGICAL PROCEDURE, IS MEDICALLY NECESSARY AS PART OF THE TREATMENT OF THE COVERED PERSON AND THAT, IN THE PROVIDER'S CLINICAL JUDGMENT, TO INTERRUPT OR DELAY THE PROVISION OF CARE TO THE COVERED PERSON IN ORDER TO OBTAIN PRIOR AUTHORIZATION FOR THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE WOULD NOT BE MEDICALLY ADVISABLE;

(B) THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE IS A COVERED BENEFIT UNDER THE COVERED PERSON'S HEALTH BENEFIT PLAN;

(C) THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE IS NOT EXPERIMENTAL OR INVESTIGATIONAL;

(D) AFTER COMPLETING THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE AND BEFORE SUBMITTING A CLAIM FOR PAYMENT, THE PROVIDER NOTIFIES THE CARRIER OR ORGANIZATION THAT THE PROVIDER PERFORMED THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE AND INCLUDES IN THE NOTICE THE INFORMATION REQUIRED UNDER THE CARRIER'S OR ORGANIZATION'S CURRENT PRIOR AUTHORIZATION REQUIREMENTS POSTED IN ACCORDANCE WITH SUBSECTION (2)(a)(I) OF THIS SECTION; AND

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(E) THE PROVIDER IS COMPLIANT WITH THE CARRIER'S OR ORGANIZATION'S POST-SERVICE CLAIMS PROCESS, INCLUDING SUBMISSION OF THE CLAIM WITHIN THE CARRIER'S OR ORGANIZATION'S REQUIRED TIMELINE FOR CLAIMS SUBMISSIONS.

(II) WHEN A PROVIDER PROVIDES AN ADDITIONAL OR A RELATED HEALTH-CARE PROCEDURE AS DESCRIBED IN THIS SUBSECTION (4)(c), THE CARRIER OR ORGANIZATION SHALL NOT DENY THE CLAIM FOR THE INITIAL SURGICAL PROCEDURE FOR WHICH THE CARRIER OR ORGANIZATION APPROVED A PRIOR AUTHORIZATION REQUEST ON THE BASIS THAT THE PROVIDER PROVIDED THE ADDITIONAL OR RELATED HEALTH-CARE PROCEDURE.

(5) **Duration of approval.** (a) Upon approval by the carrier or organization, a prior authorization is valid for at least one ~~hundred eighty days~~ CALENDAR YEAR after the date of approval and continues for the duration of the authorized course of treatment. Except as provided in subsection (5)(b) of this section, once approved, a carrier or AN organization shall not retroactively deny the prior authorization request for a health-care service.

(6) **Rules - enforcement.** (a) The commissioner may adopt rules as necessary to implement this section.

(b) THE COMMISSIONER MAY ENFORCE THE REQUIREMENTS OF THIS SECTION AND IMPOSE A PENALTY OR OTHER REMEDY AGAINST A PERSON THAT VIOLATES THIS SECTION.

(7) **Definitions.** As used in this section:

(e) "Private utilization review organization" or "organization" ~~has the same meaning as set forth~~ MEANS A PRIVATE UTILIZATION REVIEW ORGANIZATION, AS DEFINED in section 10-16-112 (1)(a), THAT HAS A CONTRACT WITH AND PERFORMS PRIOR AUTHORIZATION ON BEHALF OF A CARRIER.

SECTION 3. In Colorado Revised Statutes, 10-16-124.5, **amend** (2)(a)(II)(A), (2)(c)(II)(A), (3)(a) introductory portion, (3)(a)(I), (3)(a)(VI), (3)(b) introductory portion, (5), and (6); **repeal** (3)(a)(II) and (4); and **add** (3.3), (3.5), (5.5), and (6.5) as follows:

10-16-124.5. Prior authorization form - drug benefits - rules of commissioner - definitions - repeal. (2) (a) Except as provided in subsection (2)(b) or (2)(c) of this section, a prior authorization request is deemed granted if a carrier or pharmacy benefit management firm fails to:

(II) For prior authorization requests submitted electronically:

(A) Notify the prescribing provider, within two business days after receipt of the request, that the request is approved, denied, or incomplete, and if incomplete,

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indicate the specific additional information, consistent with criteria posted pursuant to ~~subparagraph (II) of paragraph (a) of subsection (3)~~ SUBSECTION (3.5)(a) of this section, that is required to process the request; or

(c) For nonurgent prior authorization requests related to a covered person's HIV prescription drug coverage, the prior authorization request is deemed granted if a carrier or pharmacy benefit management firm fails to:

(II) For prior authorization requests submitted electronically:

(A) Notify the prescribing provider within one business day after receipt of the request that the request is approved, denied, or incomplete, and if incomplete, indicate the specific additional information, consistent with criteria posted pursuant to ~~subsection (3)(a)(II)~~ SUBSECTION (3.5)(a) of this section, that is required to process the request; or

(3) (a) ~~On or before July 31, 2014,~~ The commissioner shall develop, by rule, a uniform prior authorization process that:

(I) Is made available electronically by the carrier or pharmacy benefit management firm, ~~but that~~ does not require the prescribing provider to submit a prior authorization request electronically, AND SATISFIES THE REQUIREMENTS OF SUBSECTION (3.3) OF THIS SECTION;

(II) ~~Requires each carrier and pharmacy benefit management firm to make the following available and accessible in a centralized location on its website:~~

~~(A) Its prior authorization requirements and restrictions, including a list of drugs that require prior authorization;~~

~~(B) Written clinical criteria that are easily understandable to the prescribing provider and that include the clinical criteria for reauthorization of a previously approved drug after the prior authorization period has expired; and~~

~~(C) The standard form for submitting requests;~~

(VI) Requires carriers and pharmacy benefit management firms, when notifying a prescribing provider of its decision to deny a prior authorization request, to include THE INFORMATION REQUIRED BY SECTION 10-16-112.5 (3)(c)(II) AND a notice that the covered person has a right to appeal the adverse determination pursuant to sections 10-16-113 and 10-16-113.5.

(b) In developing the uniform prior authorization process, the commissioner shall take into consideration ~~the recommendations, if any, of the work group established pursuant to subsection (4) of this section and~~ the following:

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(3.3) STARTING JANUARY 1, 2027, IF A PROVIDER SUBMITS A PRIOR AUTHORIZATION REQUEST TO A CARRIER OR PBM THROUGH A SECURE ELECTRONIC TRANSMISSION SYSTEM THE CARRIER OR PBM USES THAT COMPLIES WITH THE MOST RECENT VERSION OF THE NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS SCRIPT STANDARD, OR ITS SUCCESSOR STANDARD, AND 21 CFR 1311, THE CARRIER OR PBM SHALL ACCEPT AND RESPOND TO THE REQUEST THROUGH THE SECURE ELECTRONIC TRANSMISSION SYSTEM.

(3.5) (a) ON AND AFTER JANUARY 1, 2026, A CARRIER SHALL POST ON THE CARRIER'S PUBLIC-FACING WEBSITE, IN A READILY ACCESSIBLE, STANDARDIZED, SEARCHABLE FORMAT, PRIOR AUTHORIZATION REQUIREMENTS AS APPLICABLE TO THE PRESCRIPTION DRUG FORMULARY FOR EACH HEALTH BENEFIT PLAN THE CARRIER OFFERS, INCLUDING THE FOLLOWING INFORMATION:

(I) THE CARRIER'S PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, INCLUDING A LIST OF DRUGS THAT REQUIRE PRIOR AUTHORIZATION;

(II) WRITTEN CLINICAL CRITERIA THAT ARE EASILY UNDERSTANDABLE TO THE PRESCRIBING PROVIDER AND THAT INCLUDE THE CLINICAL CRITERIA FOR REAUTHORIZATION OF A PREVIOUSLY APPROVED DRUG AFTER THE PRIOR AUTHORIZATION PERIOD HAS EXPIRED;

(III) THE STANDARD FORM FOR SUBMITTING PRIOR AUTHORIZATION REQUESTS;

(IV) THE HEALTH BENEFIT PLAN TO WHICH THE FORMULARY APPLIES;

(V) EACH PRESCRIPTION DRUG THAT IS COVERED UNDER THE HEALTH BENEFIT PLAN, INCLUDING BOTH GENERIC AND BRAND-NAME VERSIONS OF A PRESCRIPTION DRUG;

(VI) ANY PRESCRIPTION DRUGS ON THE FORMULARY THAT ARE PREFERRED OVER OTHER PRESCRIPTION DRUGS OR ANY ALTERNATIVE PRESCRIPTION DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION;

(VII) ANY EXCLUSIONS FROM OR RESTRICTIONS ON COVERAGE, INCLUDING:

(A) ANY TIERING STRUCTURE, INCLUDING COPAYMENT AND COINSURANCE REQUIREMENTS;

(B) PRIOR AUTHORIZATION, STEP THERAPY, AND OTHER UTILIZATION MANAGEMENT CONTROLS;

(C) QUANTITY LIMITS; AND

(D) WHETHER ACCESS IS DEPENDENT UPON THE LOCATION WHERE A PRESCRIPTION DRUG IS OBTAINED OR ADMINISTERED; AND

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(VIII) THE APPEAL PROCESS FOR A DENIAL OF COVERAGE OR ADVERSE DETERMINATION FOR AN ITEM OR SERVICE FOR A PRESCRIPTION DRUG.

(b) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO IMPLEMENT THIS SUBSECTION (3.5).

(4) ~~(a) Within thirty days after May 15, 2013, the commissioner shall establish a work group comprised of representatives of:~~

~~(I) The department of regulatory agencies;~~

~~(II) Local and national carriers;~~

~~(III) Captive and noncaptive pharmacy benefit management firms;~~

~~(IV) Providers, including hospitals, physicians, advanced practice registered nurses with prescriptive authority, and pharmacists;~~

~~(V) Drug manufacturers;~~

~~(VI) Medical practice managers;~~

~~(VII) Consumers; and~~

~~(VIII) Other stakeholders deemed appropriate by the commissioner.~~

~~(b) The work group shall assist the commissioner in developing the prior authorization process and shall make recommendations to the commissioner on the items set forth in paragraph (b) of subsection (3) of this section. The work group shall report its recommendations to the commissioner no later than six months after the commissioner appoints the work group members. Regardless of whether the work group submits recommendations to the commissioner, the commissioner shall not delay or extend the deadline for the adoption of rules creating the prior authorization process as specified in paragraph (a) of subsection (3) of this section.~~

(5) (a) Notwithstanding any other provision of law, ~~on and after January 1, 2015~~ AND EXCEPT AS PROVIDED IN SUBSECTIONS (5)(b) AND (5.5) OF THIS SECTION, every prescribing provider shall use the prior authorization process developed pursuant to subsection (3) of this section to request prior authorization for coverage of drug benefits, and every carrier and pharmacy benefit management firm shall use that process for prior authorization for drug benefits.

(b) (I) A CARRIER OR PBM THAT PROVIDES DRUG BENEFITS UNDER A HEALTH BENEFIT PLAN SHALL NOT IMPOSE PRIOR AUTHORIZATION REQUIREMENTS UNDER THE HEALTH BENEFIT PLAN MORE THAN ONCE EVERY THREE YEARS FOR A DRUG THAT IS APPROVED BY THE FDA AND THAT IS A CHRONIC MAINTENANCE DRUG IF THE

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CARRIER OR PBM HAS PREVIOUSLY APPROVED A PRIOR AUTHORIZATION FOR THE COVERED PERSON FOR USE OF THE CHRONIC MAINTENANCE DRUG.

(II) THIS SUBSECTION (5)(b) DOES NOT APPLY IF:

(A) THERE IS EVIDENCE THAT THE AUTHORIZATION WAS OBTAINED FROM THE CARRIER OR PBM BASED ON FRAUD OR MISREPRESENTATION;

(B) FINAL ACTION BY THE FDA OR OTHER REGULATORY AGENCIES, OR THE MANUFACTURER, REMOVES THE CHRONIC MAINTENANCE DRUG FROM THE MARKET, LIMITS ITS USE IN A MANNER THAT AFFECTS THE AUTHORIZATION, OR COMMUNICATES A PATIENT SAFETY ISSUE THAT WOULD AFFECT THE AUTHORIZATION ALONE OR IN COMBINATION WITH OTHER AUTHORIZATIONS;

(C) A GENERIC EQUIVALENT OR DRUG THAT IS BIOSIMILAR, AS DEFINED IN 42 U.S.C. SEC. 262 (i)(2), TO THE PRESCRIBED CHRONIC MAINTENANCE DRUG IS ADDED TO THE CARRIER'S OR PBM'S DRUG FORMULARY; OR

(D) THE WHOLESALE ACQUISITION COST OF THE CHRONIC MAINTENANCE DRUG EXCEEDS A DOLLAR AMOUNT AS ESTABLISHED BY THE COMMISSIONER BY RULE, WHICH AMOUNT MUST BE NO LESS THAN THIRTY THOUSAND DOLLARS FOR A TWELVE-MONTH SUPPLY OR FOR A COURSE OF TREATMENT THAT IS LESS THAN TWELVE MONTHS IN DURATION.

(III) NOTHING IN THIS SUBSECTION (5)(b) REQUIRES A CARRIER OR PBM TO PAY FOR A BENEFIT:

(A) THAT IS NOT A COVERED BENEFIT UNDER THE HEALTH BENEFIT PLAN; OR

(B) IF THE PATIENT IS NO LONGER A COVERED PERSON UNDER THE HEALTH BENEFIT PLAN ON THE DATE THE CHRONIC MAINTENANCE DRUG WAS PRESCRIBED, DISPENSED, ADMINISTERED, OR DELIVERED.

(IV) AS USED IN THIS SUBSECTION (5)(b), "CHRONIC MAINTENANCE DRUG" HAS THE MEANING SET FORTH IN SECTION 12-280-103 (9.5).

(5.5) (a) NO LATER THAN JANUARY 1, 2026, A CARRIER OR PBM SHALL ADOPT A PROGRAM, DEVELOPED IN CONSULTATION WITH PROVIDERS PARTICIPATING WITH THE CARRIER, TO ELIMINATE OR SUBSTANTIALLY MODIFY PRIOR AUTHORIZATION REQUIREMENTS IN A MANNER THAT REMOVES THE ADMINISTRATIVE BURDEN FOR QUALIFIED PROVIDERS, AS DEFINED UNDER THE PROGRAM, AND THEIR PATIENTS FOR CERTAIN PRESCRIPTION DRUGS AND RELATED DRUG BENEFITS BASED ON ANY OF THE FOLLOWING:

(I) THE PERFORMANCE OF PROVIDERS WITH RESPECT TO ADHERENCE TO

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NATIONALLY RECOGNIZED, EVIDENCE-BASED MEDICAL GUIDELINES, APPROPRIATENESS, EFFICIENCY, AND OTHER QUALITY CRITERIA; AND

(II) PROVIDER SPECIALTY, EXPERIENCE, OR OTHER OBJECTIVE FACTORS; EXCEPT THAT ELIGIBILITY FOR THE PROGRAM MUST NOT BE LIMITED BY PROVIDER SPECIALTY.

(b) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION:

(I) MUST NOT REQUIRE QUALIFIED PROVIDERS TO REQUEST PARTICIPATION IN THE PROGRAM; AND

(II) MAY INCLUDE LIMITING THE USE OF PRIOR AUTHORIZATION TO PROVIDERS WHOSE PRESCRIBING OR ORDERING PATTERNS DIFFER SIGNIFICANTLY FROM THE PATTERNS OF THEIR PEERS AFTER ADJUSTING FOR PATIENT MIX AND OTHER RELEVANT FACTORS AND IN ORDER TO PRESENT THOSE PROVIDERS WITH OPPORTUNITIES FOR IMPROVEMENT IN ADHERENCE TO THE CARRIER'S OR ORGANIZATION'S PRIOR AUTHORIZATION REQUIREMENTS.

(c) AT LEAST ANNUALLY, A CARRIER OR PBM SHALL:

(I) REEXAMINE A PROVIDER'S PRESCRIBING OR ORDERING PATTERNS;

(II) REEVALUATE THE PROVIDER'S STATUS FOR EXEMPTION FROM PRIOR AUTHORIZATION REQUIREMENTS OR FOR INCLUSION IN THE PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION; AND

(III) NOTIFY THE PROVIDER OF THE PROVIDER'S STATUS FOR EXEMPTION OR INCLUSION IN THE PROGRAM.

(d) A PROGRAM DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION MUST INCLUDE PROCEDURES FOR A PROVIDER TO REQUEST:

(I) AN EXPEDITED, INFORMAL RESOLUTION OF A CARRIER'S OR PBM'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM; AND

(II) IF THE MATTER IS NOT RESOLVED THROUGH INFORMAL RESOLUTION, BINDING ARBITRATION AS SPECIFIED IN SUBSECTION (5.5)(e) OF THIS SECTION.

(e) IF A PROVIDER REQUESTS BINDING ARBITRATION PURSUANT TO THE PROCEDURES A CARRIER OR A PBM DEVELOPS UNDER SUBSECTION (5.5)(d)(II) OF THIS SECTION, THE FOLLOWING PROVISIONS GOVERN THE ARBITRATION PROCEDURE:

(I) THE PROVIDER AND CARRIER OR PBM SHALL JOINTLY SELECT AN ARBITRATOR FROM THE LIST OF ARBITRATORS APPROVED PURSUANT TO SECTION 10-16-704 (15)(b). NEITHER THE PROVIDER NOR THE CARRIER OR PBM IS REQUIRED TO NOTIFY THE DIVISION OF THE ARBITRATION OR OF THE SELECTED ARBITRATOR.

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(II) THE SELECTED ARBITRATOR SHALL DETERMINE THE PROVIDER'S ELIGIBILITY TO PARTICIPATE IN THE CARRIER'S OR PBM'S PROGRAM BASED ON THE PROGRAM CRITERIA DEVELOPED PURSUANT TO SUBSECTION (5.5)(a) OF THIS SECTION;

(III) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR ACCEPTS THE MATTER, THE PROVIDER AND THE CARRIER OR PBM SHALL SUBMIT TO THE ARBITRATOR WRITTEN MATERIALS IN SUPPORT OF THEIR RESPECTIVE POSITIONS;

(IV) THE ARBITRATOR MAY RENDER A DECISION BASED ON THE WRITTEN MATERIALS SUBMITTED PURSUANT TO SUBSECTION (5.5)(e)(III) OF THIS SECTION OR MAY SCHEDULE A HEARING, LASTING NOT LONGER THAN ONE DAY, FOR THE PROVIDER AND CARRIER OR PBM TO PRESENT EVIDENCE;

(V) WITHIN THIRTY DAYS AFTER THE DATE THE ARBITRATOR RECEIVES THE WRITTEN MATERIALS OR, IF A HEARING IS CONDUCTED, THE DATE OF THE HEARING, THE ARBITRATOR SHALL ISSUE A WRITTEN DECISION STATING WHETHER THE PROVIDER IS ELIGIBLE FOR THE PROGRAM; AND

(VI) IF THE ARBITRATOR OVERTURNS THE CARRIER'S OR PBM'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM, THE CARRIER OR PBM SHALL PAY THE ARBITRATOR'S FEES AND COSTS, AND IF THE ARBITRATOR AFFIRMS THE CARRIER'S OR PBM'S FAILURE OR REFUSAL TO INCLUDE THE PROVIDER IN THE PROGRAM, THE PROVIDER SHALL PAY THE ARBITRATOR'S FEES AND COSTS.

(6) Upon approval by the carrier or pharmacy benefit management firm, a prior authorization is valid for at least one ~~hundred eighty days~~ CALENDAR YEAR after the date of approval. If, as a result of a change to the carrier's formulary, the drug for which the carrier or pharmacy benefit management firm has provided prior authorization is removed from the formulary or moved to a less preferred tier status, the change in the status of the previously approved drug does not affect a covered person who received prior authorization before the effective date of the change for the remainder of the covered person's plan year. Nothing in this subsection (6) limits the ability of a carrier or pharmacy benefit management firm, in accordance with the terms of the health benefit plan, to substitute a generic drug, with the prescribing provider's approval and patient's consent, for a previously approved brand-name drug.

(6.5) THE COMMISSIONER MAY ENFORCE THE REQUIREMENTS OF THIS SECTION AND IMPOSE A PENALTY OR OTHER REMEDY AGAINST A PERSON THAT VIOLATES THIS SECTION.

SECTION 4. Appropriation. (1) For the 2024-25 state fiscal year, $36,514 is appropriated to the department of regulatory agencies for use by the division of insurance. This appropriation is from the division of insurance cash fund created in section 10-1-103 (3)(a)(I), C.R.S. To implement this act, the division may use this appropriation as follows:

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(a) $29,332 for personal services, which amount is based on an assumption that the division will require an additional 0.4 FTE; and

(b) $7,182 for operating expenses.

SECTION 5. Act subject to petition - effective date - applicability. (1) This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2024 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) This act applies to conduct occurring on or after January 1, 2026.

Approved: June 3, 2024

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