Legislative Council Staff
Nonpartisan Services for Colorado's Legislature

Issue Brief
October 2024

Health Care Prior Authorization Practices

Prior authorization—sometimes referred to as preauthorization or precertification—is a process by which an insurer reviews a request for health care services or drugs before consenting to cover the costs of the proposed treatment. Upon receiving a request, an insurer can approve or deny the request, or request additional information from the patient or their health care provider. Health insurers may require prior authorization for a variety of reasons, including cost control and verification of medical necessity. This issue brief provides an overview of the prior authorization practices used by health insurers, including private health insurance carriers and public insurers such as Medicaid.

Medical Services Requiring Prior Authorization

Not all medical services require prior authorization to be covered by health insurance. Every health insurer sets its own rules for which services require prior authorization. So while prior authorization might be required one insurer, it may not be required by another. Often, specialty drugs and relatively expensive medical services such as complex surgery require prior authorization from a health insurer, while more common health services and drugs do not.[1]

Colorado's Medicaid program, Health First Colorado, requires prior authorization requests (PARs) to be approved for the following services:[2]

- long-term home health, including home health needs beyond 60 days;
- certain dental services;
- non-emergency ambulance services (e.g., transfers between health facilities);
- outpatient surgery at an ambulatory surgery center;
- organ and other transplant services;
- breast reconstruction surgery;
- private duty nursing;
- certain behavioral health services including but not limited to residential treatment for substance use disorders;
- non-generic prescription drugs and durable medical equipment;
- outpatient physical, occupational, and speech therapies;
- certain lab and radiology services; and
- certain preventative services, and chronic disease management.

Recent Colorado Legislation

From 2019 through 2024, the Colorado General Assembly passed several bills to place new limits and requirements on the use of PARs for certain services or situations, both for

[1] Prior Authorization, healthinsurance.org: https://www.healthinsurance.org/glossary/prior-authorization.

[2] Health First Colorado Benefits and Services: https://www.healthfirstcolorado.com/benefits-services; Colorado PAR Program, HCPF: https://hcpf.colorado.gov/par.

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Medicaid and state-regulated health insurers, as outlined below.

Medicaid Legislative Impacts

House Bill 22-1290 prohibits Medicaid from requiring PARs for wheelchair repairs.

Senate Bill 22-156 prohibits Medicaid from requiring PARs for outpatient psychotherapy services and retroactively recovering provider payments under certain circumstances including when prior authorization was erroneously given.

House Bill 23-1183 makes modifications to Medicaid's PARs for prescription drug coverage. Before receiving prior authorization for a prescription drug that is not on Medicaid's preferred drug list, a patient is required to fail on an alternative drug on Medicaid's preferred drug list—this process is known as step-therapy. HB 23-1183 requires Medicaid to:

- review applications to exempt patients from the step-therapy process under certain conditions; and
- make PARs for coverage of prescription drugs and a description of the step-therapy exemption process available on its website.

Senate Bill 24-110 prohibits Medicaid from requiring a patient to try and fail treatment on more than one preferred antipsychotic drugs before paying for a non-preferred drug. Previously Medicaid required a patient to try two preferred drugs before covering a non-preferred drug.

Private Insurers Legislative Impacts

House Bill 19-1211 directs health insurance carriers to:

- post current PARs on their website;
- post data regarding approvals and denials of PARs;
- use current, clinically-based criteria for reviewing PARs and to align these criteria with those used by other carriers;
- respond to PARs within five business days, with some exceptions, or the request is deemed automatically approved;
- treat an approved request as valid for at least 180 days; and
- provide notice of changes to PAR practices at least 90 days in advance of the change taking effect.

House Bill 24-1149 makes several changes to PAR practices by health insurers including:

- requiring carriers to annually review and eliminate prior authorization requirements for services and drugs if they do not promote health care quality or equity, nor reduce health care spending;
- prohibiting carriers from denying claims for procedures related to a surgery for which prior authorization was already given, if the claim meets certain criteria;
- requiring carriers to implement a program that eliminates or substantially modifies prior authorization administrative processes for qualified health care providers meeting certain criteria; and
- encouraging carriers to exempt providers with at least an 80 percent approval rate from prior authorization requirements; and
- requiring carriers to provide relevant alternatives when a prior authorization request is denied.