HB1149_L.004

HOUSE COMMITTEE OF REFERENCE AMENDMENT

Committee on Health & Human Services.

HB24-1149 be amended as follows:

Amend printed bill, page 4, line 6, after "(2)(c)," insert "(3)(a)(I),", and after "**add**" insert "(3)(c)(III), (3.5),".

Page 7, line 20, strike "(c) (II) If" and substitute "(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 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".

Page 7, line 24, strike "must include" and substitute "must:

(A) Include".

Page 7, line 27, strike "MEDICATIONS" and substitute "TREATMENTS".

Page 8, strike line 1 and substitute: "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".

Page 8, after line 3 insert:

"(3.5) (a) STARTING JANUARY 1, 2026, 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.

(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.".

Page 13, line 6, after "**add**" insert "(3.3),".

Page 13, after line 12 insert:

"(3.3) STARTING JANUARY 1, 2026, 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 THOUGH THE SECURE ELECTRONIC TRANSMISSION SYSTEM.".

Page 15, after line 22 insert:

"(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; OR

(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.

(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.".

Renumber succeeding subparagraph accordingly.

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