Bill Summary
2nd Session of the 59th Legislature

Bill No.:	**SB 441**
Version:	**FS**
Request No.:	**3639**
Author:	**Sen. Garvin**
Date:	**03/12/2024**

Bill Analysis

SB 441 creates the Ensuring Transparency in Prior Authorization Act. The measure requires each utilization review entity to make current prior authorization requirements and restrictions readily accessible on its website to enrollees and health care providers. Such an entity is prohibited from implementing any new or amended prior authorization requirements or restrictions unless the entity's website has been updated to reflect the change. The utilization review entity shall provide notice of the change to relevant contracted health care providers and enrollees at least 60 days prior to implementation of the change. Adverse determinations shall be made by a licensed physician or mental health professional. Entities affected by an adverse determination shall be notified in the time period outlined in the measure. Appeals shall be reviewed by such professionals. The measure requires any health benefit plan offered after January 1, 2027, to implement and maintain a Prior Authorization Application Programming Interface (API). Health care providers must have electronic health records or practice management systems that are compatible with the API no later than July 1, 2027.

Staff of the utilization review entity shall be available at least 8 a day during normal business hours for inbound telephone calls regarding prior authorization issues. The measure prohibits such entities from requiring an approved prior authorization request for pre-hospital transportation or prior to the provision of emergency health care services. Enrollees shall be given at least a 24-hour period following an emergency admission or rendering emergency health care services to notify the utilization review entity of the admission or rendering of emergency health care services. Each entity must approve a prior authorization request for emergency health care services necessary to screen and stabilize an enrollee. No utilization review entity may revoke, limit, condition, or restrict an approved prior authorization request if care is provided within 45 business days from the date the health care provider received approval for the prior authorization. An approved prior authorization request shall be valid for 1 year from the date that the health care provider receives an approved prior authorization determination.

Prepared by: Kalen Taylor