

WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 4840

By Delegates Chiarelli, Amos, and Hite

[Introduced January 27, 2026; referred to the
Committee on Health and Human Resources]

1 A BILL to amend and reenact §5-16-7f, §9-5-32, §33-15-4s, §33-16-3dd, §33-24-7s, §33-25-8p,
2 and §33-25a-8s of the Code of West Virginia, 1931, as amended, relating to prior
3 authorization; and clarifying that federally qualified health centers are exempted from the
4 prior authorization gold card process.

Be it enacted by the Legislature of West Virginia:

**CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE
GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL;
BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,
COMMISSIONS, OFFICES, PROGRAMS, ETC.**

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-7f. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being
4 managed, including tests, procedures, and rehabilitation initially requested by the health care
5 practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That
6 any additional testing or procedures related or unrelated to the specific medical problem,
7 condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from the Public Employees

14 Insurance Agency regarding the coverage of a service or medication.

15 (b) The Public Employees Insurance Agency shall require prior authorization forms,
16 including any related communication, to be submitted via an electronic portal and shall accept one
17 prior authorization for an episode of care. The portal shall be placed in an easily identifiable and
18 accessible place on the Public Employees Insurance Agency's webpage and the portal web
19 address shall be included on the insured's insurance card. The portal shall:

20 (1) Include instructions for the submission of clinical documentation;

21 (2) Provide an electronic notification to the health care provider confirming receipt of the
22 prior authorization request for forms submitted electronically;

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
24 durable medical equipment, and anything else for which the Public Employees Insurance Agency
25 requires a prior authorization. The standard for including any matter on this list shall be science-
26 based using a nationally recognized standard. This list shall be updated at least quarterly to
27 ensure that the list remains current;

28 (4) Inform the patient if the Public Employees Insurance Agency requires a plan member to
29 use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient
30 has completed step therapy as required by the Public Employees Insurance Agency and the step
31 therapy has been unsuccessful, this shall be clearly indicated on the form, including information
32 regarding medication or therapies which were attempted and were unsuccessful; and

33 (5) Be prepared by July 1, 2024.

34 (c) The Public Employees Insurance Agency shall provide electronic communication via
35 the portal regarding the current status of the prior authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization
37 electronically, and all of the information as required is provided, the Public Employees Insurance
38 Agency shall respond to the prior authorization request within five business days from the day on
39 the electronic receipt of the prior authorization request: *Provided, That the Public Employees*

Insurance Agency shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the Public Employees Insurance Agency shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization, request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The Public Employees Insurance Agency shall render a decision within two business day after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the Public Employees Insurance Agency wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by the Public Employees Insurance Agency is carried over to all other managed care organizations and health insurers for three months if the services are provided within the state.

(h) The Public Employees Insurance Agency shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Public Employees Insurance Agency and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The Public Employees Insurance Agency's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed \$5,000 per day and the health care practitioner shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) All federally qualified health centers shall be exempt from having to obtain a prior authorization for behavioral health services and if if a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Public Employees Insurance Agency shall not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the Public Employees Insurance Agency allows: *Provided*, That at the end of the six-month time frame, or longer if the Public Employees Insurance Agency allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the

92 previously granted time period, or longer if the Public Employees Insurance Agency allows. This
93 exemption is subject to internal auditing, at any time, by the Public Employees Insurance Agency
94 and may be rescinded if the Public Employees Insurance Agency determines the health care
95 practitioner is not performing services or procedures in conformity with the Public Employees
96 Insurance Agency's benefit plan, it identifies substantial variances in historical utilization, or
97 identifies other anomalies based upon the results of the Public Employees Insurance Agency's
98 internal audit. The Public Employees Insurance Agency shall provide a health care practitioner
99 with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection
100 may be interpreted to prohibit the Public Employees Insurance Agency from requiring a prior
101 authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or
102 any out-of-network service or procedure.

103 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
104 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
105 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
106 after the effective date of this section.

107 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
108 needed, to oversee compliance with this article. The data shall include, but not be limited to, prior
109 authorizations requested by health care providers, the total number of prior authorizations denied
110 broken down by health care provider, the total number of prior authorizations appealed by health
111 care providers, the total number of prior authorizations approved after appeal by health care
112 providers, the name of each gold card status physician, and the name of each physician whose
113 gold card status was revoked and the reason for revocation.

114 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section.

CHAPTER 9. HUMAN SERVICES.

§9-5-32.

Prior

authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being
4 managed, including tests, procedures, and rehabilitation initially requested by the health care
5 practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That
6 any additional testing or procedures related or unrelated to the specific medial problem, condition,
7 or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from the Bureau for Medical
14 Services about the coverage of a service or medication.

15 (b) The Bureau for Medical Services shall require prior authorization forms, including any
16 related communication, to be submitted via an electronic portal and shall accept one prior
17 authorization for an episode of care. The portal shall be placed in an easily identifiable and
18 accessible place on the Bureau for Medical Services' webpage and the portal web address shall
19 be included on the insured's insurance card. The portal shall:

20 (1) Include instructions for the submission of clinical documentation;

21 (2) Provide an electronic notification to the health care provider confirming receipt of the
22 prior authorization request for forms submitted electronically;

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
24 durable medical equipment, and anything else for which the Bureau of Medical Services requires a
25 prior authorization. The standard for including any matter on this list shall be science-based using
26 a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list

27 remains current;

28 (4) Inform the patient if the Bureau for Medical Services requires a plan member to use
29 step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has
30 completed step therapy as required by the Bureau for Medical Services and the step therapy has
31 been unsuccessful, this shall be clearly indicated on the form, including information regarding
32 medication or therapies which were attempted and were unsuccessful; and

33 (5) Be prepared by July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior
35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization
37 electronically, and all of the information as required is provided, the Bureau of Medical Services
38 shall respond to the prior authorization request within five business days from the day on the
39 electronic receipt of the prior authorization request, except that the Bureau of Medical Services
40 shall respond to the prior authorization request within two business days if the request is for
41 medical care or other service for a condition where application of the time frame for making routine
42 or non-life-threatening care determinations is either of the following:

43 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
44 patient's psychological state; or

45 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
46 condition, would subject the patient to adverse health consequences without the care or treatment
47 that is the subject of the request.

48 (e) If the information submitted is considered incomplete, the Bureau for Medical Services
49 shall identify all deficiencies, and within two business days from the day on the electronic receipt of
50 the prior authorization request, return the prior authorization to the health care practitioner. The
51 health care practitioner shall provide the additional information requested within three business
52 days from the day the return request is received by the health care practitioner. The Bureau for

Medical Services shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the Bureau for Medical Services wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by the Bureau for Medical Services is carried over to all other managed care organizations and health insurers for three months if the services are provided within the state.

(h) The Bureau for Medical Services shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Bureau for Medical Services and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The Bureau for Medical Services' medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed \$5,000 per day and the health care practitioner shall note on the prescription or notify the

79 pharmacy that the prescription is being provided at discharge. After the three-day time frame, a
80 prior authorization shall be obtained.

81 (2) If the approval of a prior authorization requires a medication substitution, the
82 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

83 (k) All federally qualified health centers shall be exempt from having to obtain a prior
84 authorization for behavioral health services and If ~~if~~ a health care practitioner has performed an
85 average of 30 procedures per year and in a six-month time period during that year has received a
86 90 percent final prior approval rating, the Bureau for Medical Services may not require the health
87 care practitioner to submit a prior authorization for at least the next six months or longer if the
88 Bureau for Medical Services allows: *Provided*, That at the end of the six-month time frame, or
89 longer if the Bureau for Medical Services allows, the exemption shall be reviewed prior to renewal.
90 If approved, the renewal shall be granted for a time period equal to the previously granted time
91 period, or longer if the Bureau for Medical Services allows. This exemption is subject to internal
92 auditing at any time by the Bureau for Medical Services and may be rescinded if the Bureau for
93 Medical Services determines the health care practitioner is not performing services or procedures
94 in conformity with the Bureau for Medical Services' benefit plan, it identifies substantial variances
95 in historical utilization or identifies other anomalies based upon the results of the Bureau for
96 Medical Services' internal audit. The Bureau for Medical Services shall provide a health care
97 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in
98 this subsection may be interpreted to prohibit the Bureau for Medical Services from requiring a
99 prior authorization for an experimental treatment, non-covered benefit, pharmaceutical
100 medication, or any out-of-network service or procedure.

101 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
102 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
103 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
104 after the effective date of this section.

(m) The Inspector General shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Inspector General may assess a civil penalty for a violation of this section.

CHAPTER33. INSURANCE.

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-4s.

Prior

authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member to use step therapy protocols as set forth in this chapter. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the health insurer shall respond to the prior authorization request within two business days if the request is for medical care or other service for

a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health insurer is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and

background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) All federally qualified health centers shall be exempt from having to obtain a prior authorization for behavioral health services and If if a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the health insurer's internal

93 audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for
94 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an
95 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit,
96 pharmaceutical medication, or any out-of-network service or procedure.

97 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
98 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
99 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
100 after the effective date of this section.

101 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
102 needed, to oversee compliance with this article. The data shall include, but not be limited to, prior
103 authorizations requested by health care providers, the total number of prior authorizations denied
104 broken down by health care provider, the total number of prior authorizations appealed by health
105 care providers, the total number of prior authorizations approved after appeal by health care
106 providers, the name of each gold card status physician, and the name of each physician whose
107 gold card status was revoked and the reason for revocation.

108 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
109 pursuant to §33-3-11 of this code.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.

§33-16-3dd. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being
4 managed including tests, procedures, and rehabilitation initially requested by the health care
5 practitioner to be performed at the site of service, excluding out-of-network care: *Provided*, That
6 any additional testing or procedures related or unrelated to the specific medical problem,
7 condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from a health insurer about the
14 coverage of a service or medication.

15 (b) The health insurer shall require prior authorization forms, including any related
16 communication, to be submitted via an electronic portal and shall accept one prior authorization for
17 an episode of care. The portal shall be placed in an easily identifiable and accessible place on the
18 health insurer's webpage and the portal web address shall be included on the insured's insurance
19 card. The portal shall:

20 (1) Include instructions for the submission of clinical documentation;

21 (2) Provide an electronic notification to the health care provider confirming receipt of the
22 prior authorization request for forms submitted electronically;

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
24 durable medical equipment, and anything else for which the health insurer requires a prior
25 authorization. The standard for including any matter on this list shall be science-based using a
26 nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
27 remains current;

28 (4) Inform the patient if the health insurer requires a plan member to use step therapy
29 protocols. This shall be conspicuous on the prior authorization form. If the patient has completed
30 step therapy as required by the health insurer and the step therapy has been unsuccessful, this
31 shall be clearly indicated on the form, including information regarding medication or therapies
32 which were attempted and were unsuccessful; and

33 (5) Be prepared by July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the time the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a managed care organization is carried over to health

60 insurers, the Public Employees Insurance Agency, and all other managed care organizations for
61 three months if the services are provided within the state.

62 (h) The health insurer shall use national best practice guidelines to evaluate a prior
63 authorization.

64 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
65 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
66 the peer review shall be with a health care practitioner, similar in specialty, education, and
67 background. The health insurer's medical director has the ultimate decision regarding the appeal
68 determination and the health care practitioner has the option to consult with the medical director
69 after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall
70 take no longer than five business days from the date of request of the peer-to-peer consultation.
71 Time frames regarding the appeal of a decision on a prior authorization shall take no longer than
72 10 business days from the date of the appeal submission.

73 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
74 authorization may not be subject to prior authorization requirements and shall be immediately
75 approved for not less than three days: *Provided*, That the cost of the medication does not exceed
76 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
77 prescription is being provided at discharge. After the three-day time frame, a prior authorization
78 shall be obtained.

79 (2) If the approval of a prior authorization requires a medication substitution, the
80 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

81 (k) All federally qualified health centers shall be exempt from having to obtain a prior
82 authorization for behavioral health services and if if a health care practitioner has performed an
83 average of 30 procedures per year and in a six-month time period during that year has received a
84 90 percent final prior approval rating, the health insurer may not require the health care practitioner
85 to submit a prior authorization for at least the next six months, or longer if the insurer allows:

86 *Provided*, That, at the end of the six-month time frame, or longer if the insurer allows, the
87 exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time
88 period equal to the previously granted time period, or longer if the insurer allows. This exemption is
89 subject to internal auditing by the health insurer at any time and may be rescinded if the health
90 insurer determines the health care practitioner is not performing services or procedures in
91 conformity with the health insurer's benefit plan, it identifies substantial variances in historical
92 utilization, or identifies or anomalies based upon the results of the health insurer's internal audit.
93 The insurer shall provide a health care practitioner with a letter detailing the rationale for
94 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an
95 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit,
96 pharmaceutical medication, or any out-of-network service or procedure.

97 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
98 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
99 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
100 after the effective date of this section.

101 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
102 needed, to oversee compliance with this article. The data shall include, but not be limited to, prior
103 authorizations requested by health care providers, the total number of prior authorizations denied
104 broken down by health care provider, the total number of prior authorizations appealed by health
105 care providers, the total number of prior authorizations approved after appeal by health care
106 providers, the name of each gold card status physician, and the name of each physician whose
107 gold card status was revoked and the reason for revocation.

108 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
109 pursuant to §33-3-11 of this code.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE

**CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH
SERVICE CORPORATIONS.**

§33-24-7s.**Prior****authorization.**

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically.

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by, July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all

deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health insurer is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately

75 approved for not less than three days: *Provided*, That the cost of the medication does not exceed
76 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
77 prescription is being provided at discharge. After the three-day time frame, a prior authorization
78 shall be obtained.

79 (2) If the approval of a prior authorization requires a medication substitution, the
80 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

81 (k) All federally qualified health centers shall be exempt from having to obtain a prior
82 authorization for behavioral health services and if if a health care practitioner has performed an
83 average of 30 procedures per year and in a six-month time period during that year has received a
84 90 percent final prior approval rating, the health insurer may not require the health care practitioner
85 to submit a prior authorization for at least the next six months, or longer if the insurer allows:
86 *Provided*, That, at the end of the six-month time frame, or longer if the insurer allows, the
87 exemption shall be reviewed prior to renewal. If approved, this renewal, shall be granted for a time
88 period equal to the previously granted time period, or longer if the insurer allows. This exemption is
89 subject to internal auditing, at any time, by the health insurer and may be rescinded if the health
90 insurer determines the health care practitioner is not performing services or procedures in
91 conformity with the health insurer's benefit plan, it identifies substantial variances in historical
92 utilization or identifies other anomalies based upon the results of the health insurer's internal audit.
93 The insurer shall provide a health care practitioner with a letter detailing the rationale for
94 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an
95 insurer from requiring a prior authorization for an experimental treatment, non-covered benefit,
96 pharmaceutical medication, or any out-of-network service or procedure.

97 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
98 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
99 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
100 after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section pursuant to §33-3-11 of this code.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8p.

Prior

authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from a health insurer about the coverage of a service or medication.

(b) The health insurer shall require prior authorization forms, including any related

communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. These forms shall be placed in an easily identifiable and accessible place on the health insurer's webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health insurer requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the health insurer requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the health insurer and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the health insurer shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: *Provided*, That the health insurer shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care

determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the health insurer shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The health insurer shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care provider fails to submit additional information the prior authorization is considered denied and a new request shall be submitted.

(f) If the health insurer wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a health insurer is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health insurer shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health insurer and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The health insurer's medical director has the ultimate decision regarding the appeal

determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) All federally qualified health centers shall be exempt from having to obtain a prior authorization for behavioral health services and If if a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the health insurer may not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the insurer allows: *Provided*, That, at the end of the six-month time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer is the insurer allows. This exemption is subject to internal auditing, at any time, by the health insurer and may be rescinded if the health insurer determines the health care practitioner is not performing services or procedures in conformity with the health insurer's benefit plan, it identifies substantial variance in historical utilization, or other anomalies based upon the results of the health insurer's internal audit. The insurer shall provide a health care practitioner with a letter detailing the rationale for revocation of

his or her exemption. Nothing in this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(m) The Insurance Commissioner shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Insurance Commissioner may assess a civil penalty for a violation of this section pursuant to §33-3-11 of this code.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8s.

Prior

authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the

9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from a health maintenance
14 organization about the coverage of a service or medication.

15 (b) The health maintenance organization shall require prior authorization forms, including
16 any related communication, to be submitted via an electronic portal and shall accept one prior
17 authorization for an episode of care. These forms shall be placed in an easily identifiable and
18 accessible place on the health maintenance organization's webpage and the portal web address
19 shall be included on the insured's insurance card. The portal shall:

20 (1) Include instructions for the submission of clinical documentation;

21 (2) Provide an electronic notification to the health care provider confirming receipt of the
22 prior authorization request for forms submitted electronically;

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
24 durable medical equipment, and anything else for which the health maintenance organization
25 requires a prior authorization. The standard for including any matter on this list shall be science-
26 based using a nationally recognized standard. This list shall be updated at least quarterly to
27 ensure that the list remains current;

28 (4) Inform the patient if the health maintenance organization requires a plan member to use
29 step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has
30 completed step therapy as required by the health maintenance organization and the step therapy
31 has been unsuccessful, this shall be clearly indicated on the form, including information regarding
32 medication or therapies which were attempted and were unsuccessful; and

33 (5) Be prepared by July 1, 2024.

34 (c) Provide electronic communication via the portal regarding the current status of the prior

35 authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization
37 electronically, and all of the information as required is provided, the health maintenance
38 organization shall respond to the prior authorization request within five business days from the day
39 on the electronic receipt of the prior authorization request, except that the health maintenance
40 organization shall respond to the prior authorization request within two business days if the
41 request is for medical care or other service for a condition where application of the time frame for
42 making routine or non-life-threatening care determinations is either of the following:

43 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
44 patient's psychological state; or

45 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
46 condition, would subject the patient to adverse health consequences without the care or treatment
47 that is the subject of the request.

48 (e) If the information submitted is considered incomplete, the health maintenance
49 organization shall identify all deficiencies, and within two business days from the day on the
50 electronic receipt of the prior authorization request, return the prior authorization to the health care
51 practitioner. The health care practitioner shall provide the additional information requested within
52 three business days from the day the return request is received by the health care practitioner. The
53 health insurer shall render a decision within two business days after receipt of the additional
54 information submitted by the health care provider. If the health care provider fails to submit the
55 additional information, the prior authorization is considered denied and a new request shall be
56 submitted.

57 (f) If the health maintenance organization wishes to audit the prior authorization or if the
58 information regarding step therapy is incomplete, the prior authorization may be transferred to the
59 peer review process within two business days from the day on the electronic receipt of the prior
60 authorization request.

(g) A prior authorization approved by a health maintenance organization is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for three months if the services are provided within the state.

(h) The health maintenance organization shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the health maintenance organization and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The health maintenance organization's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq.* of this code.

(k) All federally qualified health centers shall be exempt from having to obtain a prior authorization for behavioral health services and If if a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a

87 90 percent final prior approval rating, the health maintenance organization may not require the
88 health care practitioner to submit a prior authorization for at least the next six months or longer if
89 the insurer allows: *Provided*, That at the end of the six-month time frame, or longer if the insurer
90 allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be
91 granted for a time period equal to the previously granted time period, or longer if the insurer allows.
92 This exemption is subject to internal auditing, at any time, by the health maintenance organization
93 and may be rescinded if the health maintenance organization determines the health care
94 practitioner is not performing services or procedures in conformity with the health maintenance
95 organization's benefit plan, it identifies substantial variances in historical utilization, or identifies
96 other anomalies based upon the results of the health maintenance organization's internal audit.
97 The insurer shall provide a health care practitioner with a letter detailing the rationale for
98 revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit an
99 insurer from requiring prior authorization for an experimental treatment, non-covered benefit, or
100 any out-of-network service or procedure. This subsection shall not apply to pharmaceutical
101 medications or services or procedures where the benefit maximums or minimums have been
102 required by statute or policy of the Bureau for Medical Services as it relates to the Medicaid
103 Program.

104 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
105 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to
106 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
107 after the effective date of this section.

108 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
109 needed, to oversee compliance with this article. The data shall include, but not be limited to, prior
110 authorizations requested by health care providers, the total number of prior authorizations denied
111 broken down by health care provider, the total number of prior authorizations appealed by health
112 care providers, the total number of prior authorizations approved after appeal by health care

113 providers, the name of each gold card status physician, the name of each physician whose gold
114 card status was revoked and the reason for revocation.
115 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
116 pursuant to §33-3-11 of this code.

NOTE: The purpose of this bill is to exempt federally qualified health centers from having to obtain a prior authorization for behavioral health services.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.