Illinois State Medical Society

Fact Sheet: How Does House Bill 711 Reform the Prior Authorization Process in Illinois?

The Prior Authorization Reform Act is now law. This top ISMS initiative focused on the following substantive and important changes to insurer prior authorization (PA) practices.

Transparency

The new law increases transparency by requiring payers to make information about prior authorization policies readily available at the point of care.

Previously, it could be difficult and time consuming to figure out which services needed prior authorization or how prior authorization determinations were made.

Timelines

The new law standardizes response times by requiring utilization review organizations to respond to prior authorization requests within specific timeframes.

Before the new law was enacted, physicians and patients often had to wait weeks before utilization review organizations responded to their prior authorization requests, causing unnecessary delays in patient care.

Adverse Determinations

The new law establishes minimum qualifications for individuals who can deny a prior authorization request and specifies the information that a utilization review organization must provide at the time of denial, which helps the physician understand what additional information may be needed to support an approval for the service.

In the past, prior authorization denials – or "adverse determinations" – were often made by non-physicians or physicians in different specialty areas with little or no experience treating the condition for which the prior authorization request was being made. Such reviewers lacked the specialized knowledge necessary to appropriately evaluate a prior authorization request.

Duration of a Prior Authorization Approval

The new law sets specific time frames for how long a prior authorization approval is valid for acute and chronic conditions, including required time frames if a patient changes health insurance plans in the middle of treatment.

Previously, prior authorization requests were required for certain services or medications, and depending on how long a patient's medical condition lasted, the physician would need to submit multiple prior authorization requests for the same service or drug, even if there had been no changes in the patient's medical status. The need to renew prior authorization approvals for patients who were stable on a prescribed treatment also caused significant disruptions in patient care that may have resulted in shorter recovery times or worse patient outcomes overall.

Fairness and Accountability

The new law prevents state-regulated insurers from changing their own rules midstream. For example, once a prior authorization request is approved, it cannot be revoked, except under certain circumstances; a covered service that receives PA approval and is billed appropriately must be paid. The new law also encourages state-regulated health plans to demand fewer PA approvals by calling for plans to periodically re-assess their prior authorization requirements.

Before the new law was enacted, utilization review programs treated prior authorization requests in a piecemeal fashion, without considering related supplies or services that were needed for successful outcomes for which a prior authorization request had been submitted (e.g., anesthesia for a surgical procedure).

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