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LEGISLATURE OF NEBRASKA

ONE HUNDRED NINTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 77

Introduced by Bostar, 29.

Read first time January 09, 2025

Committee:

A BILL FOR AN ACT relating to insurance; to adopt the Ensuring Transparency in Prior Authorization Act; to provide operative dates; and to provide severability.

Be it enacted by the people of the State of Nebraska,

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Section 1. Sections 1 to 14 of this act shall be known and may be cited as the Ensuring Transparency in Prior Authorization Act.

Sec. 2. For purposes of the Ensuring Transparency in Prior Authorization Act, unless the context otherwise requires:

(1) Adverse determination means a determination by a health carrier or its designated utilization review entity that an admission, the availability of care, a continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced, or terminated;

(2) Chronic condition means a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living or both;

(3) Clinical criteria means the written policies, written screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of health care services;

(4) Department means the Department of Insurance;

(5) Emergency health care services, with respect to an emergency medical condition as defined in 42 U.S.C. 300gg-111, means:

(a) A medical screening examination, as required under the Emergency Medical Treatment and Labor Act, or as would be required under such act if such act applied to an independent freestanding emergency department, that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(b) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as

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applicable, such further medical examination and treatment as are required under the Emergency Medical Treatment and Labor Act, or as would be required under such act if such act applied to an independent freestanding emergency department, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished;

(6) Emergency Medical Treatment and Labor Act means section 1867 of the Social Security Act, 42 U.S.C. 1395dd, and associated regulations;

(7) Enrollee means an individual who is enrolled in a health benefit plan, including covered dependents;

(8) Health benefit plan means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(9) Health care provider has the same meaning as in section 44-1303;

(10) Health care services means any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition. The term also includes the provision, administration, or prescription of pharmaceutical products or services, the provision of mental health and substance use disorder services, and the provision of durable medical equipment;

(11) Health carrier means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Director of Insurance, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include

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a managed care organization;

(12) Medically necessary means services or supplies provided by a health care provider that are:

(a) Appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury;

(b) In accordance with standards of good medical practice;

(c) Not primarily for the convenience of the enrollee or the enrollee's health care provider; and

(d) The most appropriate supply or level of service that can safely be provided to the enrollee;

(13) Notice means communication delivered either electronically or through the United States Postal Service or a common carrier;

(14) Physician means an individual licensed under the Medicine and Surgery Practice Act to practice medicine and surgery or osteopathic medicine and surgery or an individual with an equivalent license from another United States jurisdiction;

(15) Prior authorization means the process by which utilization review entities determine the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. The term includes authorization, pre-certification, and any other term that would be a reliable determination by a health benefit plan;

(16) Urgent health care service means a health care service with respect to which the application of the time periods prescribed under the Ensuring Transparency in Prior Authorization Act for making a nonexpedited prior authorization could, in the opinion of a physician with knowledge of the enrollee's medical condition:

(a) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(b) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the

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utilization review;

(17) Utilization review entity means an individual or entity that performs prior authorization for a health benefit plan; and

(18) Value-based arrangement means an agreement between a health carrier and a health care provider that rewards the provider for quality, effectiveness, or efficiency through shared cost savings.

Sec. 3. (1) A utilization review entity, including any third-party entity utilized by the health carrier, shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its website to enrollees and health care providers. Prior authorization requirements shall be described in detail but also in easily understandable language. Prior authorization requirements shall also be made available on the website in a machine-readable format no later than January 1, 2027.

(2) If a utilization review entity intends either to implement a new prior authorization requirement or restriction or to amend an existing requirement or restriction, the utilization review entity shall:

(a) Ensure that the new or amended requirement or restriction is not implemented unless the utilization review entity's website has been updated to reflect the new or amended requirement or restriction; and

(b) Provide contracted health care providers who are credentialed to perform the affected health care service, or enrollees who have a chronic condition and are already receiving such service, notice of the new or amended requirement or restriction no less than sixty days before the requirement or restriction is implemented.

Sec. 4. (1) A utilization review entity shall ensure that all adverse determinations are made by a physician. Such physician shall:

(a) Possess a current and valid nonrestricted license in a United States jurisdiction;

(b) Have the appropriate training, knowledge, or expertise to apply appropriate clinical guidelines to the health care service being

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requested; and

(c) Make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of health care services provided to enrollees of Nebraska. All such medical directors must be physicians licensed in a United States jurisdiction.

(2) When an adverse determination is issued or a prior authorization is canceled or voided, the utilization review entity shall provide written notice to the requesting health care provider. The notice shall include the reason for denial, citing written clinical criteria.

(3)(a) If an adverse determination questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, or if physician review is required due to the age of the patient, the utilization review entity shall include in the notice of adverse determination the name and telephone number of a physician acting on behalf of the utilization review entity with whom the requesting health care provider, or the provider's designated proxy, shall have a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the intervention.

(b) The requesting health care provider, or the provider's designated proxy, shall have the opportunity to contact such physician at the telephone number provided within one business day of receipt of the adverse determination for an urgent health care service or within three business days of receipt of the adverse determination for a nonurgent health care service, to engage in a discussion of the patient's treatment plan and the clinical basis for the intervention. If the physician does not respond to the requesting health care provider, or the provider's designated proxy, within the required timeframe, the utilization review entity shall be deemed to have failed to provide a reasonable opportunity for discussion as required under subdivision (3)(a) of this section and the prior authorization request shall be deemed approved.

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(c) Following any discussion under subdivision (3)(b) of this section, the utilization review entity shall notify the requesting health care provider whether or not the adverse determination decision remains the same or the health care service is approved. The notice under this subdivision shall be provided (i) within one business day of the discussion between the requesting health care provider and physician for an urgent health care service or (ii) within two business days of the discussion between the requesting health care provider and physician for a nonurgent health care service.

(d) A discussion under subdivision (3)(b) of this section shall not replace or eliminate the opportunity for any internal grievance or appeal process provided by the utilization review entity.

Sec. 5. A utilization review entity shall ensure that all appeals of an adverse determination are reviewed by a physician. Such physician shall:

(1) Possess a current and valid unrestricted license in a United States jurisdiction;

(2) Be of the same or similar specialty as a physician who typically manages the medical condition in question, which means that either:

(a) The physician maintains board certification for the same or similar specialty; or

(b) The physician's training and experience (i) includes treating the condition, (ii) includes treating complications that may result from the service or procedure, and (iii) is sufficient for the physician to determine if the service or procedure is medically necessary or clinically appropriate;

(3) Not have been directly involved in making the adverse determination;

(4) Not have any financial interest in the outcome of the appeal; and

(5) Consider all known clinical aspects of the health care service

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under review, including, but not limited to, a review of those medical records which are pertinent and relevant to the active condition provided to the utilization review entity by the enrollee's health care provider, or a health care facility, and any pertinent medical literature provided to the utilization review entity by the health care provider.

Sec. 6. (1) On or before November 1, 2025, the department shall approve a uniform prior authorization request form for prescription drugs, devices, and durable medical equipment and a uniform prior authorization request form for all other health care procedures, treatments, and services. The uniform prior authorization request forms shall not exceed two printed pages in length. This two-page limit does not apply to or include a health care provider's notes or documentation that the provider submits in support of a prior authorization request.

(2) Beginning January 1, 2026, all health care providers shall use only the approved uniform prior authorization request forms and all health benefit plans and utilization review entities shall accept and process prior authorization requests submitted using such forms.

(3) This section does not prohibit a health carrier from using a prior authorization methodology that uses an Internet webpage, an Internet webpage portal, or a similar web-based system if the methodology is consistent with the uniform prior authorization request forms approved by the department pursuant to this section.

Sec. 7. (1) If a utilization review entity requires prior authorization of a health care service, the utilization review entity shall make a prior authorization or adverse determination and provide notice of its decision to the enrollee and the enrollee's health care provider in accordance with the following timeframes:

(a) For purposes of approving a prior authorization for urgent health care services, within twelve hours of obtaining all necessary information to make the prior authorization or adverse determination; or

(b) For purposes of approving a prior authorization for nonurgent

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health care services, within three days of obtaining all necessary information to make the prior authorization or adverse determination.

(2) For purposes of this section, necessary information includes, but is not limited to, the results of any face-to-face clinical evaluation or second opinion that may be required.

(3) Health care services are deemed authorized if a utilization review entity fails to comply with the deadlines set forth in this section.

(4) In the notice to the health care provider that a prior authorization has been approved, the utilization review entity shall include the duration of the prior authorization or the date by which the prior authorization will expire.

Sec. 8. No utilization review entity shall require prior authorization of:

(1) Emergency confinement or an emergency health care service;

(2) Pre-hospital transportation for the provision of emergency health care services or for transfers between facilities as required by the Emergency Medical Treatment and Labor Act;

(3) Cancer care that is consistent with guidelines of the National Comprehensive Cancer Network;

(4) Services that have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as described in 45 C.F.R. 147.130; or

(5) Services covered through a value-based arrangement.

Sec. 9. (1) A health benefit plan shall not revoke, limit, condition, or restrict a prior authorization if care is provided within sixty days from the date the health care provider received the prior authorization unless the enrollee was no longer eligible for care on the day care was provided.

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(2) A health benefit plan shall pay a contracted health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization, unless:

(a) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment under the health benefit plan;

(b) The health care service was no longer a covered benefit on the day it was provided;

(c) The health care provider was no longer contracted with the patient's health benefit plan on the date the care was provided;

(d) The health care provider failed to meet the utilization review entity's timely filing requirements; or

(e) The patient was no longer eligible for health care coverage on the day the care was provided.

Sec. 10. (1) Except as otherwise provided in this section, prior authorization shall be valid for at least one year from the date the health care provider receives the prior authorization, and the authorization period shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

(2) If a prior authorization is required for a health care service, other than for inpatient acute care, for the treatment of a chronic condition of an enrollee, the prior authorization shall remain valid for the length of the treatment.

(3) If a prior authorization is required for inpatient acute care for the treatment of a chronic condition of an enrollee, the prior authorization shall remain valid for at least fourteen calendar days from the date the health care provider receives the prior authorization approval. If an enrollee requires inpatient acute care beyond the length of stay that was previously approved by the utilization review entity, then the utilization review entity shall evaluate any prior authorization

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requests for the continuation of inpatient acute care according to the provisions of the Ensuring Transparency in Prior Authorization Act. A utilization review entity shall not use any stricter criteria to determine medical necessity and appropriateness of the continuation of inpatient acute care than the criteria used to evaluate the initial request for authorization of inpatient acute care. A utilization review entity shall review any relevant and pertinent literature or data provided by the health care provider to determine the medical necessity and appropriateness of the requested length of stay or continuation of inpatient acute care. A prior authorization for the continuation of inpatient acute care shall remain valid for a maximum of fourteen calendar days from the date the health care provider receives the prior authorization approval. If a utilization review entity fails to respond to a health care provider's timely prior authorization request for the continuation of inpatient acute care before the termination of the previously approved length of stay, then the health benefit plan shall continue to compensate the health care provider at the contracted rate for inpatient acute care provided until the utilization review entity issues its determination on the prior authorization request. For purposes of this section, a timely prior authorization request for the continuation of inpatient acute care means a request that is submitted at least seventy-two hours prior to the termination of the previously approved prior authorization and includes all necessary information for the utilization review entity to make a determination. If a utilization review entity issues an adverse determination to a health care provider's prior authorization request for continuation of inpatient acute care and the health care provider appeals the adverse determination according to the provisions of the Ensuring Transparency in Prior Authorization Act, then the health benefit plan shall continue to compensate the health care provider at the contracted rate for inpatient acute care provided until the appeal has been finalized.

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(4) This section does not require a health benefit plan to cover care, treatment, or services for a health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Sec. 11. (1) On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial sixty days of an enrollee's coverage under a new health benefit plan. During such time period, a utilization review entity may perform its own review to grant a prior authorization.

(2) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.

(3) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company without any act on behalf of the health care provider.

Sec. 12. (1) An artificial intelligence-based algorithm shall not be the sole basis of a utilization review entity's decision to deny, delay, or modify health care services based, in whole or in part, on medical necessity.

(2) A utilization review entity shall disclose to the department, to each health care provider in its network, to each enrollee, and on its public website if artificial intelligence-based algorithms are used or will be used in the utilization review process.

(3) The department may, at any time, audit a utilization review entity's automated utilization management system. The department may

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contract with a third-party entity to perform an audit pursuant to this section.

Sec. 13. A utilization review entity shall not:

(1) Be compensated based on its volume of denials; or

(2) Base any incentive or penalty for a medical reviewer of such entity based on the volume of denials such reviewer issues or upholds.

Sec. 14. (1) On or before March 1, 2027, and on or before March 1 of each year thereafter, each health carrier shall report to the department, on a form prescribed by the department, the following data related to the health carrier's prior authorization practices and experience for the most recently completed calendar year:

(a) The number of prior authorization requests;

(b) The number of prior authorization requests denied;

(c) The number of appeals of adverse determinations received;

(d) The number of adverse determinations reversed on appeal;

(e) The ten individual health care services most frequently denied; and

(f) The ten reasons most frequently used to deny prior authorization requests.

(2) On or before June 1, 2027, and on or before June 1 of each year thereafter, the department shall report the data collected pursuant to subsection (1) of this section. The report shall be posted on the department's website and shall be accessible to the public.

Sec. 15. Sections 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, and 14 of this act become operative on January 1, 2026. The other sections of this act become operative on their effective date.

Sec. 16. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.