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National Council of Insurance Legislators (NCOIL)

Prior Authorization Reform Model Act

Sponsored by Sen. Walter Michel (MS)

****Draft as of March 26, 2025. To be introduced and discussed during the Health Insurance & Long Term Care Issues Committee on April 25, 2025.***

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Section 1. Title

This Act shall be known as the "[State] Prior Authorization Reform Act."

Section 2. Purpose

The purpose of this Act is to: protect the health care professional-patient relationship from unreasonable third-party interference; prevent prior authorization programs from hindering the independent medical judgment of a physician or other health care provider; and to ensure the transparency of a fair and consistent process for health care providers and their patients.

Section 3. Applicability and Scope

This Act applies to every health insurance issuer and all health benefit plans, as both terms are defined in xxxxxx, and all private review agents and utilization review plans, as both terms are defined in xxxxx, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974 or health care provided pursuant to the Workers' Compensation Act. This Act does not diminish the duties and responsibilities under other federal or state law or rules promulgated under those laws applicable to a health insurer, health insurance issuer, health benefit plan, private review agent or utilization review plan, including, but not limited to, the requirement of a certificate in accordance with xxxxx.

Section 4. Definitions

For purposes of this act, unless the context requires otherwise, the following terms shall have the meanings as defined in this section:

(A) "Adverse determination" means a determination by a health insurance issuer that, based on the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(B) "Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination.

(C) "Approval" means a determination by a health insurance issuer that a health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity and appropriateness.

(c) “Chronic condition” is a diagnosis of disease dependent on duration (a condition lasting 12 months or longer) and its effect on the patient based on one or both of the following criteria: the condition results in the need for ongoing intervention with medical products, treatment, services, and special equipment and the condition places limitations on self-care, independent living, and social interactions.

(D) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health insurance issuer to determine the necessity and appropriateness of health care services.

(E) "Department" means the [State] Department of Insurance.

(F) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(i) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(G) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(H) "Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

(I) "Health care professional" means a physician, a registered professional nurse or other individual appropriately licensed or registered to provide health care services.

(J) "Health care provider" means any physician, hospital, ambulatory surgery center, or other person or facility that is licensed or otherwise authorized to deliver health care services.

(K) "Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health and pharmaceutical services and products.

(L) "Health insurance issuer" has the meaning given to that term in [applicable state insurance statute]. Any provision of this act that applies to a "health insurance issuer" also applies to any person or entity covered under the scope of this act.

(M) "Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms and that are:

(i) In accordance with generally accepted standards of medical practice; and

(ii) Clinically appropriate in terms of type, frequency, extent, site and duration and are considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member or other interested party, but focused on what is best for the patient's health outcome.

(j) “Notice” means communication delivered both electronically and through the US Postal Service or common carrier.

(N) "Physician" means any person with a valid doctor of medicine, doctor of osteopathy or doctor of podiatry degree.

(O) "Prior authorization" means the process by which a health insurance issuer determines the medical necessity and medical appropriateness of an otherwise covered health care service before the rendering of such health care service. "Prior authorization" includes any health insurance issuer's requirement that an enrollee, health care professional or health care provider notify the health insurance issuer before, at the time of, or concurrent to providing a health care service.

(P) "Urgent health care service" means a health care service with respect to which the application of the time periods 180 for making a non-expedited prior authorization that in the opinion of a treating health care professional or health care provider with knowledge of the enrollee's medical condition:

(i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function;
(ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; or
(iii) Could lead to likely onset of an emergency 190 medical condition if the service is not rendered during the time period to render a prior authorization determination for an urgent medical service.

(Q) "Urgent health care service" does not include emergency services.

(R) "Private review agent" has the meaning given to that term in [applicable statutory reference].

Section 5. Disclosure and review of prior authorization requirements.

(A) A health insurance issuer shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health insurance issuer.

(B) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals and health care providers. Content published by a third party and licensed for use by a health insurance issuer may be made available through the health insurance issuer's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate for each service subject to prior authorization:

(1) When prior authorization became required for policies issued or health benefit plan documents delivered in [State], including the effective date or dates and the termination date or dates, if applicable, in [State];

(2) The date the [State]-specific requirement was listed on the health insurance issuer's, health benefit plan's, or private review agent's website;

(3) Where applicable, the date that prior authorization was removed for [State]; and

(4) Where applicable, access to a standardized electronic prior authorization request transaction process.

(C) The clinical review criteria must:

(1) Be based on nationally recognized, generally accepted standards except where state law provides its own standard;

(2) Be developed in accordance with the current standards of a national medical accreditation entity;

(3) Ensure quality of care and access to needed health care services;

(4) Be evidence-based;

Commented [BC1]: Grounded in up-to-date peer-reviewed clinical guidelines and medical literature.

(5) Be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and

(6) Be evaluated and updated by practicing physicians in relevant specialties, if necessary, at least annually.

(D) A health insurance issuer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(E) A health insurance issuer shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(1) An associated health care service has received prior authorization; or

(2) Prior authorization for the health care service is not required.

(F) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented. Written notice may take the form of a conspicuous notice posted on the health insurance issuer's public website or portal for contracted health care professionals and contracted health care providers. A health insurance issuer shall provide email notices to health care professionals or health care providers if the health care professional or health care provider has requested to receive the notice through email. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's website has been updated to reflect the new or amended requirement or restriction. Written notice of a new, amended, or restricted prior authorization requirement, as required by this subsection (6), may be provided less than sixty (60) days in advance if a health insurance issuer determines and contemporaneously notifies the department in writing that:

(1) The health insurance issuer has identified fraudulent or abusive practices related to the health care service;

(2) The health care service is unavailable or scarce which necessitates the use of an alternative health care service;

(3) The health care service is newly introduced to the health care market and a delay in providing coverage for the health care service and would not be in the best interests of enrollees;

(4) The health care service is the subject of a clinical trial authorized by the United States Food and Drug Administration; or

(5) Changes to the health care service or its availability are otherwise required by law to be made by the health insurance issuer in less than sixty (60) days.

(G) Health insurance issuers using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format.

Commented [BC2]: Possibly add race and ethnicity PA denial statistics. Disaggregated data might allow for more comparisons. Might be beneficial to break out differences (imaging, procedures, BH, Rx, etc.,).

Following each calendar year, the statistics must be updated annually by [Insert date], and include all of the following information:

(1) A list of all health care services, including medications, that are subject to prior authorization;

(2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services;

(3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services;

(4) The percentage of prior authorization requests that were approved after appeal, aggregated for all items and services;

(5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;

(6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;

(7) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;

(8) The average and median time that elapsed between the submission of a request and a determination by the payer, plan or health insurance issuer, for standard prior authorization, aggregated for all items and services;

(9) The average and median time that elapsed between the submission of a request and a decision by the payer, plan or health insurance issuer, for expedited prior authorizations, aggregated for all items and services; and

(10) Any other information as the department determines appropriate.

Section 6. Standardized electronic prior authorizations.

(A) If any health insurance issuer requires prior authorization of a health care service, the insurer or its designee utilization review organization shall, by [Insert date] make available a standardized electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(B) Not later than [Insert date], all health care professionals and health care providers shall be required to use the standardized electronic prior authorization request transaction process made available as required by subsection (A) of this section.

The AAFP is very supportive of electronically automating the prior authorization process, as well as decreasing the overall amount of prior authorizations. We support driving insurers and health care organizations toward standard exchange of prior authorization darta.

We are concerned though with this proposal, as it does not drive toward a standard approach across insurers. Family physicians frequently have 7-14 insurers that they work with. Going to 7-14 different portals will not decrease the administrative burden on practices to submit and track prior authorizations. We strongly recommend requiring a standard API that EHRs can build toward. If not, then practices should not be forced to use a specific electronic methodology.

Section 7. Prior authorizations in nonurgent circumstances.

If a health insurance issuer requires prior authorization of a health care service, the health insurance issuer must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as expeditiously as the enrollee's condition requires but no later than seven (7) calendar days after obtaining all necessary information to make the approval or adverse determination, unless a longer minimum time frame is required under federal law for the health insurance issuer and the health care service at issue. As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion or other clinical information that is directly applicable to the requested service that may be required. Notwithstanding the foregoing provisions of this section, health insurance issuers must comply with the requirements of [State Insurance Code Section] respond by two (2) business days for prior authorization requests for pharmaceutical services and products.

Section 8. Prior authorizations in urgent circumstances.

(A) If requested by a treating health care provider or health care professional for an enrollee, a health insurance issuer must render an approval or adverse determination concerning urgent health care services and notify the enrollee, the enrollee's health care professional and the enrollee's health care provider of that approval or adverse determination as expeditiously as the enrollee's condition requires but no later than twenty-four (24) hours after receiving all information needed to complete the review of the requested health care services, unless a longer minimum time frame is required under federal law for the health insurance issuer and the urgent health care service at issue.

(B) To facilitate the rendering of a prior authorization determination in conformance with this section, a health insurance issuer must establish a mechanism to ensure health care professionals have access to appropriately trained and licensed clinical personnel who have access to physicians, of the same training and specialty/subspecialty, for discussion of medical necessity issues.

Section 9. Notifications for adverse determinations.

Commented [BC3]: The AMA PA and UM reform principles for non-urgent care, require entities to make a determination and notify the provider within 48 hours of obtaining all necessary information. https://www.arthritis.org/getmedia/90b713f3-f95e-4b02-a030-376fd6a2de0a/AMA-Prior-Authorization-Principles.pdf

Commented [BC4]: Contact information for appeals support; whether expedited appeal is an option; credentials of who made the denial decision; notice patient right to an external or independent review.

If a health insurance issuer makes an adverse determination, the health insurance issuer shall include the following in the notification to the enrollee, the enrollee's health care professional, and the enrollee's health care provider:

(a) The reasons for the adverse determination and related evidence-based criteria, including a description of any missing or insufficient documentation;

(b) The right to appeal the adverse determination;

(c) Instructions on how to file the appeal; and timeframe for submitting the appeal

(d) Additional documentation necessary to support the appeal.

Section 10. Personnel qualified to review appeals.

(A) A health insurance issuer must ensure that all appeals are reviewed by a physician when the request is by a physician or a representative of a physician. The physician must:

(1) Possess a current and valid nonrestricted license to practice medicine in any United States jurisdiction;

(2) Be certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty of a physician who typically manages the medical condition or disease;

(3) Be knowledgeable of, and have experience providing, the health care services under appeal;

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

(5) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the health insurance issuer by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer by the health care professional or health care provider.

(B) Notwithstanding the foregoing, a licensed health care professional who satisfies the requirements in this section may review appeal requests submitted by a health care professional licensed in the same profession.

Section 11. Insurer review of prior authorization requirements.

A health insurance issuer shall periodically review its prior authorization requirements and consider removal of prior authorization requirements:

(a) Where a medication or procedure prescribed is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or

(b) For patients currently managed with an established treatment regimen.

Section 12. Revocation of prior authorizations.

(A) A health insurance issuer may not revoke or further limit, condition or restrict a previously issued prior authorization approval while it remains valid under this act.

(B) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a health insurance issuer, the health insurance issuer shall make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one (1) of the following occurs:

(1) It is timely determined that the enrollee's health care professional or health care provider knowingly and without exercising prudent clinical judgment provided health care services that required prior authorization from the health insurance issuer or its contracted private review agent without first obtaining prior authorization for those health care services;

(2) It is timely determined that the health care services claimed were not performed;

(3) It is timely determined that the health care services rendered were contrary to the instructions of the health insurance issuer or its contracted private review agent or delegated reviewer if contact was made between those parties before the service being rendered;

(4) It is timely determined that the enrollee receiving such health care services was not an enrollee of the health care plan; or

Commented [BC5]: What is the definition of timely determined?

(5) The approval was based upon a material misrepresentation by the enrollee, health care professional, or health care provider; as used in this paragraph, material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(C) Nothing in this section shall preclude a private review agent or a health insurance issuer from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

Section 13. Length of approvals. ‘

(A) A prior authorization approval shall be valid for the lesser of six (6) months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional or the renewal of the policy or plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his/her health care professional may extend a prior authorization approval for a longer period, by agreement. All dosage increases must be based on established evidentiary standards, and nothing in this section shall prohibit a health insurance issuer from having safety edits in place. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(B) Nothing in this section shall require a policy or plan to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

Section 14. Approvals for chronic conditions.

(A) If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, including, but not limited to, chemotherapy for the treatment of cancer, the approval shall remain valid for the lesser of twelve (12) months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his or her health care professional may extend a prior authorization approval for a longer period, by agreement. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(B) Nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 15. Continuity of prior approvals.

(A) On receipt of information documenting a prior authorization approval from the enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer shall honor a prior authorization granted to an enrollee from a previous health insurance issuer for at least the initial ninety (90) days of an enrollee's coverage under a new health plan, subject to the terms of the member's coverage agreement.

(B) During the time period described in subsection (A) of this section, a health insurance issuer may perform its own review to grant a prior authorization approval subject to the terms of the member's coverage agreement.

(C) 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 approval before the effective date of the change for the remainder of the enrollee's plan year.

(D) Except to the extent required by medical exceptions processes for prescription drugs, nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

Section 16. Effect of insurer's failure to comply.

A failure by a health insurance issuer to comply with the deadlines and other requirements specified in this act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted private review agent.

Section 17. Enforcement and administration.

(A) In addition to the enforcement powers granted to it by law to enforce the provisions of this act, the department is granted specific authority to issue a cease-and-desist order or require a private review agent or health insurance issuer to submit a plan of correction for violations of this act, or both. Subject to regulations promulgated by the department under the provisions of the [State] Administrative Procedure Law and after proper notice and the opportunity for a hearing, the department may impose upon a private review agent, health benefit plan or health insurance issuer an administrative fine not to exceed xxxxxx per violation for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this act. All fines collected by the department under this section shall be deposited into the State General Fund. The department may also exercise all authority granted to it under the [applicable Insurance Code section] to deny or revoke a certificate of a private review agent for a violation of this act.

(B) Any person or his or her treating physician who has evidence that his or her health insurance issuer or health benefit plan is in violation of the provisions of this act may file a complaint with the department. The department shall review all complaints received and investigate all complaints that it deems to state a potential violation. The department shall fairly, efficiently and timely review and investigate complaints. Health insurance issuers, health benefit plans and private review agents found to be in violation of this act shall be penalized in accordance with this section.

(C) The department shall have the authority to promulgate rules and regulations under the [applicable State administrative laws] to govern the administration of this act.

(D) There shall be no private right of action under this Act.

Section 18. Reports to the department.

(A) By June 1, 20xx, and each June 1 after that date, a health insurance issuer shall report to the department, on a form issued by the department, the following aggregated trend data, de-identified of protected health information, related to the insurer's practices and experience for the prior plan year for health care services submitted for payment:

(1) The number of prior authorization requests;

(2) The number of prior authorization requests denied;

(3) The number of prior authorization appeals received;

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

(5) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically;

(6) The ten (10) health care services that were most frequently denied through prior authorization;

(7) The ten (10) reasons prior authorization requests were most frequently denied;

(8) The number of claims for health care services that were examined through a post-service utilization review process;

(9) The number and percentage of claims for health care services denied through post-service utilization review; and

(10) The ten (10) health care services that were most frequently denied as a result of post-service utilization reviews.

(B) All reports required by this section shall be considered public records under the [State Public Records Act] and the department shall make all reports freely available to requestors and post all reports to its public website without redactions.

Section 19. False requests for prior authorization.

If a health insurance issuer has clear and convincing evidence that a health care professional or health care provider has knowingly and willingly submitted false or fraudulent requests for prior authorization to the health insurance issuer, the issuer shall notify and provide that information to the Commissioner of Insurance. After receipt of such notification and information, the commissioner shall forward these reports to the Board Medical Licensure or such other licensing agency with oversight of the health care provider, and the office of [relevant official authorized to prosecute/investigate insurance fraud].

Section 20. Rules

The [State Insurance Department] shall promulgate rules necessary to effectuate the purposes of this Act

Section 21. Effective Date

This Act shall take effect xxxx days after it shall have become a law.