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## National Council of Insurance Legislators (NCOIL)

### Prior Authorization Reform Model Act

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*\*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 timely and evidence-based care for patients~~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.

**Commented [A1]:** Recommend replacing this with, "timely and evidence-based care for patients;"

As written, this section could be read to indicate that PA is inherently harmful and suggests that PA is an adversarial force against providers. PA can prevent instances of provider over-utilization or inappropriate prescribing. The phrase "independent medical judgment" could also be interpreted to justify care that is not supported by clinical evidence. This revision would instead emphasize clinical standards and patient outcomes.

**Commented [A2]:** Recommend aligning the definition with the definition of "adverse benefit determination" at 29 CFR 2560.503-1(m)(4)(i).

[https://www.ecfr.gov/current/title-29/part-2560/section-2560.503-1#p-2560.503-1\(m\)\(4\)\(i\)](https://www.ecfr.gov/current/title-29/part-2560/section-2560.503-1#p-2560.503-1(m)(4)(i))

This alignment with ERISA-governed plans ensures greater consistency with federal standards - making implementation more straightforward. Additionally, the current language, while detailed, over-emphasizes specific insurer criteria, which may inadvertently make the definition overly rigid. The federal definition captures a broad range of adverse determinations while allowing an appropriate level of flexibility for health plans.

(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.

**Commented [A3]:** Recommend aligning with the definition according to EMTALA legislation [see Federal statute 42 USCS § 1395dd section e(1)(A)]

This alignment not only promotes regulatory consistency but also reduces confusion for providers and patients while helping to prevent conflicts between overlapping requirements.

(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.

(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.

**Commented [A4]:** Recommend aligning the definition with Kentucky Code 907 3:130 which defines medically necessary services:

- (1) The determination of whether a covered benefit or service is medically necessary shall:
- (a) Be based on an individualized assessment of the recipient's medical needs; and
  - (b) Comply with the requirements established in this paragraph. To be medically necessary or a medical necessity, a covered benefit shall be:
    1. Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;
    2. Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;
    3. Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons;
    4. Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
    5. Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;

This change would promote greater alignment with existing regulations, enhance clarity and reduce ambiguity in implementation.

**Commented [A5]:** Appears to have been included by mistake.

**Commented [A6]:** Appears to have been included by mistake.

(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:

**Commented [A7]:** Recommend striking this requirement to ensure the integrity and clinical accuracy of PA criteria shared with providers. While we support the overall goal of transparency, applying a general readability standard to clinical review criteria risks oversimplifying technical, evidence-based content in a way that may compromise its utility for providers.

(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

**Commented [A8]:** Recommend striking this. If a PA is removed and no longer applicable for the state, its inclusion does not provide substantial value to providers or patients of that state and would make PA documents more cumbersome.

(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;

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

(6) Be evaluated and updated, 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 for medical items and services, excluding drugs, on their website in a readily accessible format. 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, items and services that are subject to prior authorization;
- (2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services;

**Commented [A9]:** Recommend excluding prescription drugs, to read, "...denials for medical items and services, excluding drugs, on their website..."

The statistics listed in this section align with federal requirements (CMS-0057-F). Those federal requirements exclude reporting of drugs due to operational complexities - we recommend maintaining that alignment. This will allow plans to maintain consistent processes to report data aligned with both state and federal requirements.

**Commented [A10]:** Recommend listing "March 31" to align with federal requirements.  
<https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability#p-1421>

This alignment will support consistency across markets and reduce operational complexities.

**Commented [A11]:** "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, Application Programming Interface (API), 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.

**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

**Commented [A12]:** Recommend including "Application Programming Interface (API)" to clarify its inclusion.

Plans are working to implement federal requirements electronic prior authorization requirements (CMS-0057-F) which allow for transactions over a prior authorization API.

**Commented [A13]:** We strongly support and appreciate the inclusion of this provision to ensure the adoption of electronic PA which will streamline PA for providers, payers and patients.

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 forty-eight (48) 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 for consultation,

### Section 9. Notifications for adverse determinations.

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
- (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 that are upheld 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;

**Commented [A14]:** Recommend providing 72 hours to maintain alignment with Medicare Advantage to support consistency across markets and reduce operational complexities.

MA plans must respond within 72 hours for standard prior authorization requests for a Medicare Part B drug.  
<https://www.law.cornell.edu/cfr/text/42/422.568>

**Commented [A15]:** Recommend providing 72 hours to maintain alignment with federal regulations and support consistency and reduce operational complexities/confusion.

[https://img.federalregister.gov/ER08FE24.005/ER08FE24.005\\_original\\_size.png](https://img.federalregister.gov/ER08FE24.005/ER08FE24.005_original_size.png)

**Commented [A16]:** Recommend revising the language to state, "...all appeals that are upheld are reviewed by a physician..."

We recommend clarifying that not all appeals require physician-level review. Specifically, if an initial denial was issued due to missing or incomplete information, and the appeal submission includes the necessary documentation, the case should be eligible for review and overturn by an appropriately licensed nurse reviewer without physician involvement.

Mandating physician involvement in these administrative cases introduces unnecessarily delays in appeal processing, postpones patient care and does not reflect the best use of physician time on non-clinical determinations that do not require their expertise.

(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

(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

**Commented [A17]:** Appears to have been included by mistake.

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 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;

**Commented [A18]:** We recommend striking Section 18.

Section 5(G) already achieves PA transparency goals in a manner that is publicly accessible and useful for regulatory oversight.

Requiring additional reporting under Section 18 would impose unnecessary administrative and financial burdens on health plans without providing meaningful additional value. Departments can leverage the data under section 5(G) to draw conclusions and inform policymaking without imposing additional similar reporting requirements. Streamlining these requirements ensures transparency while avoiding redundant regulatory costs.

(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.