LB210
2023

LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 210

Introduced by Bostar, 29.

Read first time January 10, 2023

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to insurance; to adopt the Prior Authorization Reform Act.

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

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Section 1. Sections 1 to 6 of this act shall be known and may be cited as the Prior Authorization Reform Act.

Sec. 2. For purposes of the Prior Authorization Reform Act:

(1) Department means the Department of Insurance;

(2)(a) Health care service means a health care procedure, treatment, or service which is:

(i) Provided by a health care facility licensed in the State of Nebraska; or

(ii) Provided by a physician or osteopathic physician or within the scope of practice for which a health care professional is licensed in the State of Nebraska; and

(b) Health care service includes the provision of any pharmaceutical product or service or durable medical equipment;

(3)(a) Health carrier means an entity that is subject to the insurance laws, rules, and regulations of the State of Nebraska or is subject to the jurisdiction of the Director of Insurance and that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of any health care service, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service organization, or any other entity providing a plan of health insurance, health benefits, or health care services; and

(b) Health carrier includes a managed-care organization;

(4)(a) Prior authorization means the process by which a health carrier or utilization review entity determines the medical necessity or medical appropriateness of any otherwise covered health care service prior to the rendering of such health care service; and

(b) Prior authorization includes any requirement of a health carrier or utilization review entity that an insured individual or health care provider notify the health carrier or utilization review entity prior to providing a health care service; and

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(5) Utilization review entity means an individual or entity that performs prior authorization for a health carrier.

Sec. 3. By January 1, 2025, each health carrier shall adopt a program, developed in consultation with the health care providers participating with the health carrier, that promotes the modification of prior authorization requirements based on the following:

(1) The performance of health care providers with respect to adherence to nationally recognized, evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria;

(2) Involvement of health care providers with a health carrier to participate in a financial risk-sharing payment plan, that includes downside risk; and

(3) The specialty, experience, or other factors relating to one or more specific health care providers.

Sec. 4. (1) Any program adopted as required by section 3 of this act shall offer any provider of health care services that has at least a ninety percent approval rate of prior authorization requests over the immediately preceding six months at least one alternative to prior authorization, including an exemption from prior authorization requirements.

(2) At least annually, a health carrier or utilization review entity shall reexamine the prescribing or ordering patterns of each participating provider of health care services and reevaluate the provider's status regarding exemption from or eligibility for other alternatives to prior authorization requirements.

Sec. 5. By June 1, 2024, and each June 1 thereafter, each health carrier shall report to the department, on a form issued by the department, the following aggregated trend data related to the health carrier's prior authorization practices and experience for the preceding twelve-month period:

(1) The number of prior authorization requests;

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(2) The number of prior authorization requests denied;

(3) The number of appeals received;

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

(5) The ten individual services most frequently denied; and

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

Sec. 6. By October 1, 2024, and each October 1 thereafter, the department shall aggregate, deidentify, and compile into a report the data collected pursuant to section 5 of this act. The report shall not identify the name of any health carrier submitting data. The report shall be posted on the department's Internet website accessible to the public.