ONE HUNDRED NINTH LEGISLATURE - FIRST SESSION - 2025
COMMITTEE STATEMENT
LB77

Hearing Date: Monday February 10, 2025
Committee On: Banking, Commerce and Insurance
Introducer: Bostar
One Liner: Adopt the Ensuring Transparency in Prior Authorization Act

Roll Call Vote - Final Committee Action:

Advanced to General File with amendment(s)

Vote Results:

Aye:	8	Senators Jacobson, Bostar, Dungan, Hallstrom, Hardin, Riepe, von Gillern, Wordekemper
Nay:		
Absent:		
Present Not Voting:		

Testimony:

Proponents:	**Representing:**
Senator Eliot Bostar	Opening Presenter
Amber McLeod	Nebraska Association of Behavioral Health Organizations
Ivan Mitchell	Great Plains North Platte, Nebraska Hospital Association
Mary Wells	Nebraska Medical Association
Joe Miller	Nebraska Academy of Family Physicians
Mike Dewerff	Bryan Health
Janel Fricke	Self
Curt Coleman	CHI Health
Kevin Johnson	AARP Nebraska
Amy Garwood	Nebraska Rheumatology Society
Tami Burke	Nebraska Rheumatology Society

Opponents:	**Representing:**
Jeremiah Blake	Blue Cross Blue Shield Nebraska
Michelle Crimmins	Prime Therapeutics
Robert Bell	Nebraska Insurance Federation

Neutral:	**Representing:**

* ADA Accommodation Written Testimony

Summary of purpose and/or changes:

LB 77 would create the Ensuring Transparency in Prior Authorization Act (Act). The Act is intended to increase transparency and accountability in the prior authorization process for determining the medical necessity of health care services in order to balance the need for prior authorization against the need for timely health care services and products.

Section-by-Section Summary:

Section 1: States the sections that make up the Act.

Section 2: Provides the definitions for eighteen (18) terms that are used throughout the Act.

Section 3: Provides for how a utilization review entity and related parties must publish or make known their current prior authorization requirements and restrictions to providers and enrollees. Also provides for how these requirements and restrictions are to be updated and how contracted health care providers and certain enrollees are to be notified of new requirements and restrictions.

Section 4: Requires that utilization review entities ensure adverse determinations are made by a physician. The section states what credentials and education such a physician must possess and how they must process the adverse determinations. Provides for what information the adverse determination must contain. Provides for when and how the physician must make their contact information available to the health care provider that received the adverse determination so that the provider can engage with the physician about the denial. If the physician does not reply within one business day for an urgent health care service or within three business days for an non-urgent health care service, the prior authorization will be deemed approved. The section also creates timelines and notice requirements following the discussion between the provider and the physician about an adverse determination.

Section 5: Requires utilization review entities to create an appeals process for adverse determinations that includes review by a physician. The section also states what credentials and education that physician must have, and places other restrictions and requirements on the appeal physician.

Section 6: Tasks the Department of Insurance (DOI) with approving uniform prior authorization request forms. States that starting January 1, 2026, all health care providers shall use the approved forms and all health benefit plans and utilization review entities shall accept them. Allows for the use of online forms via Internet webpages, Internet webpage portals, or a similar web-based system if the methodology is consistent with the DOI-approved forms.

Section 7: Provides a timeline for when a utilization review entity must make a decision in the prior authorization process and states who must be notified of that decision.

Section 8: Exempts certain services or procedures from any prior authorization process.

Section 9: Creates a 60-day window in which prior authorization approvals may not be revoked by a health benefit plan. The section also requires that health benefit plans pay contracted health care providers at the contracted payment rate for health care service provided by the health care provider per a prior authorization unless certain exceptions exist.

Section 10: States that a 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. Also states that 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. Creates a 14-day window in which prior authorization

approval may not be revoked for inpatient acute care for the treatment of a chronic condition of an enrollee and provides for how and under what conditions that treatment can be continued under the prior authorization process. Finally, this section states that a health benefit plan is not required 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.

Section 11: Provides a reexamination process for when a new utilization review entity receives an enrollee's existing prior authorization from a prior utilization review entity. Places restrictions and requirements on that process.

Section 12: Places restrictions on how artificial intelligence-based algorithms may be used in the prior authorization process, and provides for how, when, and to whom the use of such algorithms must be disclosed. Also gives the DOI authority to audit automated utilization management systems.

Section 13: States that a utilization review entity shall not be compensated based on its volume of denials nor shall they base any incentive or penalty for a medical reviewer of such entity on the volume of denials such reviewer issues or upholds.

Section 14: On or before March 1, 2027, and on or before each March 1st thereafter, each health carrier shall send a report to DOI on its prior authorization practices and experiences from the prior calendar year. The section provides for what must be included in the report and provides for how and when DOI must make the data available to the public.

Section 15: Operative dates section.

Section 16: Severability clause.

Explanation of amendments:
AM 1187 is a white copy amendment to LB 77 that strikes the original sections and substitutes the entirety of the bill with the following:

Section 1: States the sections that make up the Ensuring Transparency in Prior Authorization Act (Act).

Section 2: Provides the definitions for eighteen (18) terms that are used throughout the Act.

Section 3: A utilization review agent must post its prior authorization rules, restrictions, and the clinical guidelines it uses on its website. This information needs to be accurate, up-to-date, and clearly explain what information and paperwork is needed for a prior authorization decision. By July 1, 2027, these requirements must also be searchable on its website. If a utilization review agent plans to introduce a new prior authorization rule or restriction, or change an existing one, the agent must first update its website to reflect these changes. The agent shall also give contracted health care providers at least 60 days' notice before the new or changed rule goes into effect.

Section 4: A utilization review agent must ensure that a physician makes all adverse determinations. However, if the requesting provider isn't a physician, a clinical peer of that provider can make the denial. Any physician or clinical peer making these decisions must have a valid, unrestricted license in a U.S. jurisdiction, have the right training and expertise for the requested service, and act under the clinical direction of the utilization review agent's medical director, who must be a U.S. jurisdiction-licensed physician responsible for Nebraska enrollees' care. When a prior authorization is denied, canceled, or voided, the utilization review agent must notify the requesting provider and explain the reason, citing the specific clinical review criteria used. If a prior authorization denial questions the medical necessity, appropriateness, or experimental nature of a service, the patient's health care provider can request to

discuss this with the physician or clinical peer who made the decision. This discussion can be requested within 3 business days of receiving the denial notice. This discussion isn't required or allowed for denials based on contract exclusions or non-covered benefits. After this discussion, the utilization review agent must inform the requesting provider if the denial decision stands. For urgent health care services, this notice must be given within 1 business day after the discussion, and for nonurgent health care services, within 2 business days. This discussion does not replace or eliminate the patient's right to use the utilization review agent's internal grievance or appeal process.

Section 5: When a patient appeals an adverse prior authorization decision, a physician must review the appeal. This physician must: (1) hold a current, unrestricted medical license in the U.S.; (2) be in the same or a similar specialty as the doctor who ordered the service, or have the necessary training and experience to treat the condition (demonstrated by board certification in a similar specialty or sufficient training and experience in treating the condition and its potential complications to judge medical necessity and appropriateness); (3) not have been involved in the original denial decision; (4) have no financial stake in the appeal's outcome; and (5) consider all relevant clinical information, including pertinent medical records and any relevant medical literature provided by the patient's health care provider.

Section 6: By November 1, 2025, the Department of Insurance (DOI) shall approve a standard, two-page prior authorization form for prescription drugs, devices, and durable medical equipment, and another standard, two-page form for all other health care services. This two-page limit doesn't include any extra information or paperwork the utilization review agent requires (as publicly stated) or the health care provider's notes supporting the request. Starting January 1, 2026, all health care providers shall use these approved standard forms. Also, with some exceptions, all utilization review agents must accept and process prior authorization requests submitted using these forms. However, this doesn't stop utilization review agents from using online systems for prior authorization if those systems are consistent with the approved standard forms. A utilization review agent may ask the DOI for an exemption from using the standard forms if the agent implement and maintain a specific type of electronic system (an application programming interface as defined in federal regulations) or another electronic method that automates and standardizes the prior authorization process for everyone involved. The utilization review agent must notify health care providers at least ninety days before implementing such a system.

Section 7: Before January 1, 2028, a utilization review agent shall decide on prior authorization requests and notify both the patient and the provider within: (a) 72 hours for urgent health care service requests, after getting all needed information, or (b) 7 days for nonurgent health care service requests, after getting all needed information. Starting January 1, 2028, the decision and notification timeframes become: (a) 48 hours for urgent health care service requests, after all necessary information is received, or (b) 7 days for nonurgent health service requests, after all necessary information is received. Health care providers and health carriers can agree to shorter timeframes if they are using the electronic prior authorization systems or as part of a risk-sharing agreement. If a utilization review agent misses these deadlines for making a decision, the health care service is automatically considered authorized. When a prior authorization is approved, the utilization review agent must inform the health care provider about how long the authorization is valid or the date it will expire.

Section 8: A utilization review agent is not allowed to require prior authorization for: (1) emergency room admissions or emergency medical care; (2) ambulance transportation for emergency care or legally required transfers between facilities under the federal Emergency Medical Treatment and Labor Act; or (3) services with an "A" or "B" rating from the U.S. Preventive Services Task Force, immunizations recommended by the CDC's Advisory Committee on Immunization Practices, or preventive services and screenings for women as mandated by federal regulations.

Section 9: Once a prior authorization is approved, a utilization review agent cannot revoke, limit, condition, or restrict it if the care is given within 60 days of the provider receiving the approval unless the patient was no longer eligible for care on the date it was provided. A health carrier must pay a contracted health care provider the agreed-upon rate for

services provided under an approved prior authorization unless one of the following applies: (a) the provider knowingly misrepresented the service or the patient's history to fraudulently obtain payment; (b) the service was no longer covered on the date it was provided; (c) the provider was no longer contracted with the patient's plan on the date of service; (d) the provider did not meet the utilization review agent's timely filing requirements; (e) the patient was no longer eligible for coverage on the date of service; or (f) the provider failed to get prior authorization when it was required.

Section 10: Generally, a prior authorization is valid for at least one year from the approval date. However, for prescription drugs with FDA-mandated treatment schedules or dosing limits shorter than a year, the authorization will follow that shorter timeframe. For inpatient care at a general acute hospital requiring prior authorization, the authorization will last for the entire length of stay approved by the utilization review agent. If the health care provider submits a timely request to continue inpatient care, the utilization review agent must respond before the current authorization expires. If the utilization review agent fails to respond to a timely request for continued inpatient care before the existing authorization ends, the health carrier must continue paying the provider at the contracted rate until the agent makes a decision. This doesn't prevent a provider or patient from appealing a negative decision as allowed by law. If an appeal overturns a denial and no other legal action is pending, the health carrier must pay the provider at the contracted rate for the inpatient care provided. This section doesn't require a health plan to cover care, treatment, or services for a condition that is entirely excluded from the plan's covered benefits, regardless of medical necessity.

Section 11: When a patient or their provider submits proof of an approved prior authorization from a previous utilization review agent, the new utilization review agent must honor that approval for at least the first 60 days of the patient's new health plan coverage. During this time, the new agent can conduct their own review for future authorizations. If the coverage or approval rules for a previously authorized service change, those changes won't affect any prior authorizations that were approved before the change took effect. If a patient switches to a different health insurance plan under the same insurance company, the utilization review agent must continue to honor any prior authorizations they previously granted without requiring any action from the health care provider.

Section 12: A utilization review agent cannot rely solely on artificial intelligence algorithms to deny, delay, or modify health care services based on medical necessity, whether the AI is used entirely or partially in the decision. A utilization review agent must inform the DOI, its network health care providers, its enrollees, and the public on its website if they are using or plan to use AI algorithms in its utilization review process. The DOI has the right to audit a utilization review agent's automated utilization management system at any time and can hire a third party to conduct these audits.

Section 13: A utilization review agent is prohibited from: (1) being paid based on how many prior authorization requests it denies; and (2) giving medical reviewers incentives or penalties based on the number of denials it issues or upholds.

Section 14: Provides the definitions for six (6) terms that are used in sections 14 to 16 of this act.

Section 15: Starting January 1, 2028, notwithstanding existing law (section 44-3,131), most individual and group health insurance policies (excluding limited-benefit policies) and self-funded employee benefit plans (as allowed by federal law) in Nebraska shall cover biomarker testing. Biomarker testing must be covered if: (a) it's used for diagnosing, treating, managing, or monitoring specific conditions like various cancers, autoimmune/autoinflammatory diseases, Parkinson's, ALS, Alzheimer's, rheumatoid arthritis, preeclampsia, sickle cell anemia, or cardiovascular conditions, as well as for organ/tissue transplants or pharmacogenomic testing; and (b) the test has demonstrated clinical usefulness based on medical and scientific evidence, such as FDA-approved labels and indications, CMS or Medicare contractor coverage decisions, or nationally recognized clinical guidelines. Coverage shall be provided in a manner to minimize disruptions in patient care, including the need for multiple biopsies or samples. Patients and their

prescribing doctors must have a clear, easy-to-use process to request exceptions to coverage policies, and this process must be easily found on the health carrier's website.

Section 16: The medical assistance program shall cover biomarker testing by January 1, 2028. Biomarker testing will be covered when: (a) it's used for diagnosing, treating, managing, or monitoring specific conditions like various cancers, autoimmune/autoinflammatory diseases, Parkinson's, ALS, Alzheimer's, rheumatoid arthritis, preeclampsia, sickle cell anemia, or cardiovascular conditions, as well as for organ/tissue transplants or pharmacogenomic testing; and (b) the test has demonstrated clinical usefulness based on medical and scientific evidence, such as FDA-approved labels and indications, CMS or Medicare contractor coverage decisions, or nationally recognized clinical guidelines. Coverage shall be provided in a manner to minimize disruptions in patient care, including the need for multiple biopsies or samples. Any entities that contract with the medical assistance program to provide services must offer biomarker testing with the same scope, duration, and frequency as the program itself. Both recipients and participating providers in the medical assistance program must have a clear, easy-to-use process to request exceptions to the program's coverage policies. The process shall be made assessable on the Department of Health and Human Services' website.

Section 17: Operative dates section.

Section 18: Severability clause.

Mike Jacobson, Chairperson