Draft date: 3/13/25

2025 Spring National Meeting
Indianapolis, Indiana

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, March 25, 2025
1:00 – 2:00 p.m.
JW Marriott Indianapolis—JW White River F–J—Level 1

ROLL CALL

NAIC Member	Representative	State/Territory
Grace Arnold, Chair	Grace Arnold, Chair	Minnesota
Allan L. McVey, Vice Chair	Joylynn Fix, Vice Chair	West Virginia
Mark Fowler	Yada Horace	Alabama
Lori K. Wing-Heier	Sarah Bailey	Alaska
Peter M. Fuimaono	Peter M. Fuimaono	American Samoa
Barbara D. Richardson	Fausto Burruel	Arizona
Michael Conway	Lila Cummings/Debra Judy	Colorado
Andrew N. Mais	Jared Kosky	Connecticut
Karima M. Woods	Howard Liebers	District of Columbia
Michael Yaworsky	Sheryl Parker	Florida
Dean L. Cameron	Weston Trexler	Idaho
Holly W. Lambert	Holly W. Lambert	Indiana
Doug Ommen	Andria Seip	Iowa
Vicki Schmidt	Craig VanAalst	Kansas
Sharon P. Clark	Shaun Orme	Kentucky
Robert L. Carey	Robert Wake	Maine
Michael T. Caljouw	Michael T. Caljouw	Massachusetts
Angela L. Nelson	Cynthia Amann	Missouri
Remedio C. Mafnas	Remedio C. Mafnas	N. Mariana Islands
Eric Dunning	Martin Swanson	Nebraska
Scott Kipper	Scott Kipper	Nevada
D. J. Bettencourt	Michelle Heaton	New Hampshire
Justin Zimmerman	Justin Zimmerman	New Jersey
Mike Causey	Robert Croom	North Carolina
Jon Godfread	Chrystal Bartuska	North Dakota
Judith L. French	Laura Miller	Ohio
Glen Mulready	Glen Mulready	Oklahoma
Andrew R. Stolfi	Jesse O'Brien	Oregon
Michael Humphreys	Michael Humphreys	Pennsylvania
Larry D. Deiter	Jill Kruger	South Dakota
Cassie Brown	Rachel Bowden	Texas

Jon Pike	Tanji J. Northrup	Utah
Scott A. White	Julie Blauvelt	Virginia
Patty Kuderer	Ned Gaines	Washington
Nathan Houdek	Nathan Houdek	Wisconsin

NAIC Support Staff: Jolie Matthews/Jennifer Cook

AGENDA

1. Consider Adoption of its March 10, 2025, Feb. 28, 2025, and 2024 Fall National Meeting Minutes—*Commissioner Grace Arnold (MN)* — Attachment One

2. Consider Adoption of its Working Group Reports
   —*Commissioner Grace Arnold (MN)*
   A. Employee Retirement Income Security Act (ERISA) (B) Working Group—*Robert Wake (ME)*
   B. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group—*Jane Beyer (WA)*
   C. Prescription Drug Coverage (B) Working Group—*Joylynn Fix (WV)*

3. Hear a Summary of State Prior Authorization Laws—*Olivea Myers (NAIC)*

4. Hear a Discussion on the Prior Authorization Issue
   —*Commissioner Grace Arnold (MN)*
   A. Provider Perspective—*Heather McComas (America Medical Association—AMA)*
   B. Consumer and Patient Perspective—*Lucy Culp (The Leukemia & Lymphoma Society—LLS)* and *Carl Schmid (HIV+Hepatitis Policy Institute)*
   C. Insurer Perspective—*Miranda Motter (America's Health Insurance Plans [AHIP]) and Danielle Lloyd (AHIP)*

5. Discuss Any Other Matters Brought Before the Task Force
   —*Commissioner Grace Arnold (MN)*

6. Adjournment

Agenda Item #1

Consider Adoption of its March 10 and Feb. 28, 2025, and 2024 Fall National Meeting Minutes—*Commissioner Grace Arnold (MN)*

Draft: 3/14/25

Regulatory Framework (B) Task Force
Virtual Meeting
March 10, 2025

The Regulatory Framework (B) Task Force met March 10, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, and Joylynn Fix (WV); Lori K. Wing-Heier represented by Sarah Bailey, (AK); Mark Fowler represented by Yada Horace (AL); Barbara D. Richardson (AZ); Michael Conway represented by Debra Judy (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Michael Yaworsky represented by Sheryl Parker (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Kenneth Scott and Josh Carlson (KS); Sharon P. Clark (KY); Michael T. Caljouw represented by Rebecca Butler (MA); Robert L. Carey represented by Robert Wake (ME); Angela L. Nelson (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Justin Zimmerman represented by David Wolf (NJ); Judith L. French represented by Laura Miller (OH); Glen Mulready (OK); Andrew R. Stolfi represented by Jesse O'Brien (OR); Michael Humphreys (PA); Larry D. Deiter represented by Travis Jordan and Ashley Severyn (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Shelley Wiseman and Heidi Clausen (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Ned Gaines (WA); and Nathan Houdek represented by Jody Ullman and Rebecca Rebholz (WI).

1. Adopted Revised 2025 Charges for the Prescription Drug Coverage (B) Working Group

Commissioner Arnold said the purpose of the Task Force's meeting was to consider adoption of the 2025 revised charges of the recently renamed Prescription Drug Coverage (B) Working Group. She explained that the revised charges reflect the Working Group's new name and the recently established working group under the Market Regulation and Consumer Affairs (D) Committee focusing on pharmacy benefit manager (PBM) enforcement.

Commissioner Arnold requested comments. For consistency with the other proposed revisions to the charges, Heaton suggested revising charge C to state: "Maintain a current listing of prescription drug laws and regulations and case law for reference by state insurance regulators."

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives suggest two changes in the proposed revised charges. He said the first suggested change is to strike the word "coverage" in charge A. He explained that while coverage is paramount, there are other components, including costs and pricing. As such, the NAIC consumer representatives recommend that this language be broadened to read "prescription drug regulation." Schmid said the second suggestion is to add "patient costs" to the list of subjects the Working Group is to examine in charge B. He said that while all the issues listed are important, what matters most to consumers is how much they pay for their prescription drug once it is covered.

The Task Force discussed and heard comments from various stakeholders on the proposed revised charges. Director Richardson made a motion, seconded by Commissioner Clark, to adopt the revised charges.

Commissioner Arnold asked for any additional discussion, particularly on Heaton's suggested revision to charge C. Fix made a motion, seconded by Bartuska, to narrow the scope of Heaton's suggested revision by adding the word "coverage" after "prescription drug" and adding the words "as fall under the purview of state-based insurance"

at the end. The Task Force discussed the suggested revision. After discussion, the Task Force unanimously adopted the motion accepting Fix's suggested revision to charge C.

Commissioner Clark made a motion, seconded by Director Richardson, to adopt the Task Force's 2025 revised charges for the Prescription Drug Coverage (B) Working Group, as revised (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 3/6/25

Health Insurance and Managed Care (B) Committee
and Regulatory Framework (B) Task Force
E-Vote
February 28, 2025

The Health Insurance and Managed Care (B) Committee and the Regulatory Framework (B) Task Force conducted a joint e-vote that concluded Feb. 28, 2025. The following Committee members participated: Glen Mulready, Chair, represented by Mike Rhoads (OK); Ann Gillespie, Co-Vice Chair (IL); Grace Arnold, Co-Vice Chair (MN); John F. King represented by Steve Manders (GA); Dean L. Cameron (ID); Marie Grant (MD); Anita G. Fox (MI); D.J. Bettencourt (NH); Andrew R. Stolfi represented by TK Keen (OR); Jon Pike represented by Tanji Northrup (UT); Patty Kuderer represented by John Kelcher and Alissa Julius (WA); and Allan L. McVey represented by Joylynn Fix (WV). The following Regulatory Framework (B) Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Lori K. Wing-Heier represented by Sarah Bailey, (AK); Peter M. Fuimaono (AS); Barbara D. Richardson (AZ); Michael Conway represented by Debra Judy (CO); Michael Yaworsky represented by Sheryl Parker and Stephanie Avello (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Robert L. Carey represented by Robert Wake (ME); Mick Campbell (MO); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); D.J. Bettencourt (NH); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by John Kelcher and Alissa Julius (WA); and Nathan Houdek (WI).

1. Adopted a Revised Name for Pharmaceutical Benefit Management Regulatory Issues (B) Working Group

The Committee and the Task Force conducted a joint e-vote to change the name of the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group to the Prescription Drug Coverage (B) Working Group. The motion passed with American Samoa voting “no” and Idaho and Nebraska abstaining.

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Agenda Item #2

Consider Adoption of its Working Group Reports—*Commissioner Grace Arnold (MN)*

- *Employee Retirement Income Security Act (ERISA) (B) Working Group—Robert Wake (ME)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group —Jane Beyer (WA)*
- *Prescription Drug Coverage (B) Working Group—Joylynn Fix (WV)*

2025 Spring National Meeting
Indianapolis, Indiana

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP

Tuesday, March 25, 2025
11:30 a.m. – 1:00 p.m.

Meeting Summary Report

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group met March 25, 2025. During this meeting, the Working Group:

1. Adopted its 2024 Fall National Meeting minutes.

2. Heard presentations on state legislation related to sources of clinical standards.

3. Adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters) of the NAIC Policy Statement on Open Meetings.

Draft: 11/27/24

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Denver, Colorado
November 18, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Denver, CO, Nov. 18, 2024. The following Working Group members participated: Jane Beyer, Chair (WA); Chrystal Bartuska, Vice Chair (ND); Crystal Phelps (AR); Stesha Hodges (CA); Cara Cheevers and Debra Judy (CO); Paul Lombardo (CT); Howard Liebers (DC); Elizabeth Nunes (GA); Andria Seip (IA); Joanna Coll (IL); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Amy Hoyt and Teresa Kroll (MO); Charles Whitehead (NC); Michelle Heaton (NH); Kyla Dembowski (OH); Landon Hubbart (OK); Lindsi Swartz (PA); Jill Kruger (SD); Daniel McAdams (TX); Julie Blauvelt (VA); Darcy Paskey (WI); Joylynn Fix (WV), and Tana Howard (WY).

1. Heard Presentations on the Final Federal Rule on Mental Health Parity

   A. Federal DOL

Beth Baum (U.S. Department of Labor—DOL) discussed the final rule, particularly the content requirements for comparative analyses. She said a recorded webinar with more information is available on the DOL's website. Baum said the final rule includes six steps for comparative analyses, with each building on the previous one. She said plans are expected to paint a detailed picture of how they comply with parity requirements and must provide, upon request, a list of all non-quantitative treatment limits (NQTLs) they apply. The first step is to describe the NQTL, but there is no need to include the entire policy. Plans must also identify all benefits the NQTL applies to and which classification they fit into. The next step is to identify and define the factors and evidentiary standards used to develop the NQTL, including sources. Plans can also use this step to describe how they cured previous discrimination in factors considered. The third step is to describe how the factors are used in the application of the NQTL, including how decisions on the NQTL are made and who makes them. Next, plans must demonstrate compliance with parity laws as written. She said this includes quantitative data or calculations used in designing and applying the NQTL, as well as forms and procedure manuals. She said the bulk of the material will be in the fifth step, a review of compliance with parity in operation. This is meant to be a comprehensive analysis, including data, documentation of outcomes, explanations of material differences in access, and discussion of reasonable steps taken in response to material differences. Baum said plans may describe a lack of data, but DOL expects this to be used only in narrow circumstances. The final step is to find and draw conclusions on whether the plan is compliant with parity laws. For Employee Retirement Income Security Act (ERISA) plans, a fiduciary must certify that they selected a provider to perform the analysis and monitor its completion.

Bartuska asked for confirmation on requirements applicable to qualified health plans (QHPs). Baum said the federal Centers for Medicare & Medicaid Services (CMS) could speak more directly to QHP certification requirements, but her understanding is that the rule applies the same standards to individual market plans as group plans. Bartuska asked about the certifications required for ERISA plans and whether states would receive copies of the certifications in cases when an ERISA plan is fully insured and thus subject to state regulation. Baum said the certification does not need to be included for non-ERISA plans, and they only need to provide copies of the comparative analysis to beneficiaries when they have an adverse benefit determination. She said sending copies to states would depend on how the comparative analysis is requested.

Seip asked whether the DOL would update its compliance guide or other resources to help state insurance regulators apply the new rules. Baum said the DOL would update its self-compliance tool as well as its next Report to Congress and is considering guidance on what data must be collected under the final rule.

B. BCBSA

Jennifer Jones (Blue Cross Blue Shield Association—BCBSA) presented concerns health plans have with the final rule. She said BCBSA shares the goal of improving access to mental health services for all Americans. She said BCBSA's plans have made investments to support this goal, including offering robust benefits and high-quality networks.

Jones said BCBSA is concerned that the latest parity rule will make it harder for patients to access care. She said the language on "no more restrictive" benefits could reduce medical management and access to higher acuity providers and remove guardrails that encourage providers to use evidence-based medicine. She said provider standards are problematic because some providers already have full panels, so bringing them in-network will not open appointments. She said the rule does not clarify what defines an NQTL, so some care management and other decision support could be treated as NQTLs. Jones identified some technical challenges with the rule. She said the timing is tight for implementation, with some going into effect in January 2025 and others in 2026. She said the departments should work to resolve ambiguity and differences in interpretation.

Jones asked for collaboration in addressing underlying barriers to mental health care, including expanding the use of non-clinical personnel, telehealth, and the pipeline of mental health providers.

C. LAC

Deborah Steinberg (Legal Action Center—LAC) spoke on behalf of NAIC consumer representatives. She provided examples of consumer barriers to care and offered suggestions to state insurance regulators for supporting consumers of mental health and substance use services and reducing the burden on them.

Steinberg said updated definitions in the rule will help include parity protections for benefits for those with autism, eating disorders, and gender dysphoria. She recommended states align their definitions because some state laws define these services as medical. She said the requirement for meaningful benefits would help ensure coverage for autism spectrum disorders (ASDs) and opioid use disorder. Steinberg said plans may look to different sources for standards of medical care than do providers or consumers. Consumer representatives recommend that states require plans to use non-profit professional societies' standards of care criteria, as five states do already. She said the updated non-exhaustive list of NQTLs and the requirement for evaluating outcomes data are very important for consumers.

Steinberg said the data show that mental health and substance use service providers are paid less than comparably trained medical/surgical professionals. She said consumers go out of network for mental health care at a much higher rate than for medical/surgical services. She said this data must be collected on a plan level. Steinberg said states should define the data elements to be collected rather than let plans decide. She encouraged states to adopt network adequacy standards, citing Maryland's standards as a good model because of their specificity. She said prohibiting discriminatory factors in developing NQTLs is an important element of the rule. She provided an example of a plan using out-of-network payment rates from 1983 to show that plans continue to use practices from before the passage of MHPAEA. She said it is critical for states to require the submission of comparative analyses on an annual basis because plan practices change each year. She said this will allow states to proactively address discriminatory plan elements. Steinberg said states should train front-line consumer assistance staff on parity red flags and allow them to forward complaints to investigators. She said consumers are

not equipped to file parity complaints themselves. She requested that the Working Group develop standardized guidance and templates incorporating the new rules.

Cheevers asked Jones about consumers who cannot find in-network providers and what incentives BCBSA plans use to attract providers to join networks. Jones said plans have quality expectations for any provider joining their network. Jones said patient volume is the primary leverage plans have to encourage providers to join. Plans can also offer providers data on their patient population. For mental health, she said plans have found ways to streamline the credentialing process and better support sole practitioners and other providers with less infrastructure. She said plans have supported integrating behavioral health into primary care to relieve burdens on behavioral health providers when patients are interested in having their conditions managed by primary care doctors.

Coll asked Jones whether plans are considering increasing payment amounts to behavioral health providers or revising requirements for payment through a third-party vendor. Jones said there are examples where plans have made substantial increases in payment to encourage providers to come in-network, but these plans have not seen significant gains in providers coming in-network. She said some plans believe there are providers who have full panels and would not choose to come in-network at any payment level.

Heaton asked Jones for an example of how the definition of NQTLs may limit the care management benefits that plans offer. Jones said that when care or case management is labeled as an NQTL, there is an expectation that it is delivered the same for behavioral health as medical and surgical services. She said this constrains the design and expansion of these programs, and care management does not function the same for medical and mental health needs.

Coll asked about plans that increased payment and did not see significant network growth. Jones said she would have to check with the plan to find more details. Beyer said that a Washington analysis using the state's all-payer claims database found that behavioral health providers were paid less than Medicare rates, on average, while primary and specialist medical providers were paid more than Medicare rates.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

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2025 Spring National Meeting
Indianapolis, Indiana

PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP

Monday, March 24, 2025
11:30 a.m. – 12:45 p.m.

Meeting Summary Report

The Prescription Drug Coverage (B) Working Group met March 24, 2025. During this meeting, the Working Group:

1. Adopted its 2024 Fall National Meeting minutes.

2. Heard a presentation from the HIV+Hepatitis Policy Institute on pharmacy benefit managers (PBMs) and how they function, particularly from the consumer perspective. This presentation continued the Working Group's discussion from its meeting at the 2024 Fall National Meeting.

3. Heard a presentation from Segal on prescription drug benefit management. The presentation included a PBM industry overview, a snapshot of the current PBM marketplace, and a discussion on prescription drug pricing and the lack of true transparency. It then suggested solutions to reduce prescription drug costs.

Agenda Item #3

Hear a Summary of State Prior Authorization Laws—*Olivea Myers (NAIC)*

Prior Authorization- State Law Activity

Eryn Campbell & Olivea Myers

March 25, 2025

Prior Authorization-State Law Activity

Categories Covered

- Response Times
- Retrospective Denials
- Clinical Criteria and Medical Necessity
- Qualifications of Reviewer

Prior Authorization-State Law Activity

Categories Covered-Continued

- Gold Carding
- Peer-to-Peer/Appeal Process

Prior Authorization-State Law Activity

State Bulletins on Prior Authorization

- Expanding on definitions in prior authorization statutes.
- Providing notice to substantive changes to prior authorization statutes.
- Notice of relaxation of prior authorization requirements.

Existing Research on PA Reform Impacts

- CMS estimates $15 billion savings for implementation of required electronic prior authorization.

- This study finds that on average providers spend 24 minutes on PA via phone/fax/email and 16 minutes via a health plan portal. It also finds PA costs providers between $9 and $13 per transaction for manual submission vs. just over $5 for fully electronic submissions.

- This study found that Medicare Advantage plans made a record-breaking 50 million PA decisions in 2023. Of the share of PA requests that were appealed, 82% were overturned.

Contact Us

- Eryn Campbell, eecampbell@naic.org
- Olivea Myers, omyers@naic.org

	Citation	Response Times	Retrospective denials	Clinical criteria & medical necessity	Qualifications of reviewer	Gold carding	Peer-to-peer/Appeal process
AL	27-3A-5	(a)(4)(c)(6)-Utilization review agents shall respond within two working days. (4)(b) Utilization review agents shall complete the adjudication of appeals of determination not to certify admissions, services, and procedures no later than 30 days from the date the appeal is filed and receipt of all information necessary to complete the appeal.			(a)(4)(a) On appeal, all determinations not to certify an admission, service, or procedure must be made by a physician in the same or similar general specialty as typically manages condition, procedure, or treatment.		(a)(4)(c) When initial decision not to approve is made prior to/during an ongoing service requiring review, and physician believes this warrants an immediate appeal, can appeal via phone on expedited basis (48 hours).
AK	7 AAC 120.410; Alaska Stat. § 21.07.020 ; 300gg-19a		(1) that preauthorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the preauthorizatio			(b)(1)If a group health plan, or a health insurance issuer offering group or individual health insurance issuer,1 provides or covers any benefits with respect to	

			n is based on materially incomplete or inaccurate information provided by or on behalf of the provider; (21.07.020)			services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B)-- (A) without the need for any prior authorization determination; (300gg-19a)	

AZ	ARS 20-2803	(A) A health care services plan shall provide coverage for an initial medical screening examination and any immediately necessary stabilizing treatment required without prior authorization. (C) A health care services plan may require as a condition of coverage prior authorization for health care services arising after the initial medical screening examination and immediately necessary stabilizing treatment. (E) A health care services plan that requires prior authorization under subsection C shall provide twenty-four hour access by telephone or facsimile for enrollees and providers to request prior authorization			(E) Plan personnel shall have access to a physician when necessary to make determinations regarding prior authorization.		

		for medically necessary care after the initial medical screening.					

AR	23-99-1105	(a) If a utilization review entity requires prior authorization of a nonurgent healthcare service, the utilization review entity shall make an authorization or adverse determination within two (2) business days of obtaining all necessary information to make the authorization or adverse determination. (23-99-1105) (a) A utilization review entity shall render an expedited authorization or adverse determination concerning an urgent healthcare service no later than one (1) business day after receiving all information needed to complete the review of the requested urgent healthcare service.	(b)(1) A utilization review entity shall not rescind, limit, condition, or restrict an authorization based upon medical necessity unless the utilization review entity notifies the healthcare provider at least three (3) business days before the scheduled date of the admission, service, procedure, or extension of stay. (23-99-1109) (2) Notwithstanding subdivision (b)(1) of this section, a utilization review entity may rescind, limit, condition,	(B) "Medical necessity" includes the terms "medical appropriateness", "primary coverage criteria", and any other terminology used by a utilization review entity that refers to a determination that is based in whole or in part on clinical justification for a healthcare service. (23-99-1103) (3) (A) Utilization review entities that have, by contract with vendors or third-party administrators, agreed to use licensed, proprietary, or copyrighted protected clinical criteria from the vendors or administrators, may satisfy the disclosure requirement under subdivision (a)(1) of this section by making all relevant proprietary clinical criteria available to a healthcare provider that submits a prior authorization request to the utilization review	(c)(1) An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted license to practice medicine in the State of Arkansas issued by the Arkansas State Medical Board. (23-99-1111) (2)(A) A utilization review entity shall provide a method by which a physician may request that a prior authorization request be reviewed by a physician in the same specialty as the physician making the request, by a physician in another appropriate specialty, or by a pharmacologist. (23-99-1111)	If a subscriber's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the subscriber has a terminal illness. (23-99-1108) (h) If a healthcare insurer and a healthcare provider are engaged in a value-based reimbursement arrangement for particular healthcare services or subscribers, the healthcare insurer shall not impose any prior authorization requirements for any particular healthcare service that is	(a)(1) An in-network or out-of-network healthcare provider may submit a benefit inquiry to a healthcare insurer or utilization review entity for a healthcare service not yet provided to determine whether or not the healthcare service meets medical necessity and all other requirements for payment under a health benefit plan if the healthcare service is provided to a specific subscriber. (23-99-1113) (B) The requesting healthcare provider may contact the reviewing physician at the telephone number provided with the adverse determination under subdivision (c)(3)(A) of this section within one (1) business day of receipt of the adverse

		(23-99-1106) (b)(1) A utilization review entity shall allow a subscriber and the subscriber's healthcare provider a minimum of twenty-four (24) hours following an emergency admission or provision of an emergency healthcare service for the subscriber or healthcare provider to notify the utilization review entity of the admission or provision of an emergency healthcare service. (23-99-1107) (2) If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the	or restrict an authorization if: (A) The subscriber was not covered by the health benefit plan and was not eligible to receive the requested service under the health benefit plan on the date of the admission, service, procedure, or extension of stay. (23-99-1109)	entity through a secured link on the utilization review entity's website that is accessible to the healthcare provider from the public part of its website as long as any link or access restrictions to the information do not cause any delay to the healthcare provider. (23-99-1104) (B) Found that the requirements for medical necessity and appropriateness of care have been met; and (C) Determined to pay for the healthcare service according to the provisions of the health benefit plan; (3) "Clinical criteria" means any written policy, written screening procedures, drug formularies, lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and other criteria or rationale		included in that value-based reimbursement arrangement. (23-99-1126) (a)(1) Except as provided under subdivision (a)(2) of this section, beginning on and after January 1, 2024, a healthcare provider that received approval for ninety percent (90%) or more of the healthcare provider's prior authorization requests based on a review of the healthcare provider's utilization of the particular healthcare services from January 1, 2022, through June 30, 2022, shall not be required to obtain prior authorization	determination for an urgent service, or within two (2) business days of receipt of the adverse determination for a nonurgent service, to engage in the discussion of the patient's treatment plan and the clinical basis for the intervention under subdivision (c)(3)(A) of this section. (23-99-1111)

		emergency healthcare service. (23-99-1107) (e)(1) If a subscriber receives an emergency healthcare service that requires an immediate post-evaluation or post-stabilization healthcare service, a utilization review entity shall make an authorization within sixty (60) minutes of receiving a request. (23-99-1107)		used by the utilization review entity to determine the medical necessity of a healthcare service. (23-99-1103)		for a particular healthcare service and shall be considered exempt from prior authorization requirements through September 30, 2024. (23-99-1120)	

CA	HSC s 1367.01 to 016 T. 28 s 1300.67.241	(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30		(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination. (HSC s 1367.01)	(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h). (HSC s 1367.01) (a) Health plans that utilize a prescription drug prior authorization or step therapy exception process shall use and accept only the		(a) A health care service plan shall accept premium payments from the following third-party entities without the need to comply with subdivision (c): (1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act. (H & S s 1367.016)

		days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000. (HSC s 1367.01) (2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to the enrollee's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1),			Prescription Drug Prior Authorization or Step Therapy Exception Request Form, numbered 61-211 (Revised 12/16), which is incorporated by reference and referred to hereafter in this section as "Form 61-211." This section does not apply to the following except as further specified in this regulation. (T. 28 s 1300.67.241)		

		would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.					

		(HSC s 1367.01) (2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to the enrollee's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the					

		enrollee's condition, not to exceed 72 hours. (HSC s 1367.01)					

CO	C.R.S. 10-16-124.5 C.R.S. 10-16-113 (3 CCR 702 Reg. 4-2-17 s 10)	(II) For prior authorization requests submitted electronically: (A) Notify the prescribing provider, within two business days after receipt of the request, that the request is approved, denied, or incomplete, and if incomplete, indicate the specific additional information, consistent with criteria posted pursuant to subsection (3.5)(a) of this section, that is required to process the request; or (B) Notify the prescribing provider, within two business days after receiving the additional information required by the carrier or pharmacy benefit management firm		(b) In developing the uniform prior authorization process, the commissioner shall take into consideration the following: (I) National standards pertaining to electronic prior authorization, including, but not limited to, standards referenced in federal law; (II) Whether the prior authorization process should require carriers and pharmacy benefit management firms, when reviewing a prior authorization request, to use clearly accessible, consistently applied, and written clinical criteria based on medical necessity or the appropriateness of the drug benefit for the covered person. (10-16-124.5) (III) Ensures that carriers and pharmacy benefit management	(5) All written adverse determinations, except an adverse determination described in sub-subparagraph (C) or (E) of subparagraph (I) of paragraph (b) of subsection (1) of this section, must be signed by a licensed physician familiar with standards of care in Colorado; except that, in the case of written adverse determinations relating to dental care, a licensed dentist familiar with standards of care in Colorado may sign the written adverse determination. (10-16-113) (b)(III)(A) A physician shall evaluate the first-level appeal and shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer;		A. In a case involving a prospective review determination, a carrier shall give the medical facility or health care professional rendering the service an opportunity to request, on behalf of the covered person, a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination. Such a request may be made either orally or in writing. B. The peer-to-peer conversation shall occur within five (5) calendar days of the carrier's receipt of the request and shall be conducted between the medical facility or health care professional rendering the health care service and the

		pursuant to sub-subparagraph (A) of this subparagraph (II), that the request is approved or denied; (III) For nonurgent prior authorization requests submitted orally or by facsimile or electronic mail, notify the prescribing provider, within three business days after receipt of the request, that the request is approved or denied. (C.R.S. 10-16-124.5)		firms use evidence-based guidelines, when possible, when making prior authorization determinations. (10-16-124.5)	except that, in the case of dental care, a dentist may evaluate the first-level appeal, and the reviewing dentist shall consult with an appropriate clinical peer or peers, unless the reviewing dentist is a clinical peer. A physician, dentist, or clinical peer who was involved in the initial adverse determination shall not evaluate or be consulted regarding the first-level appeal. A person who was previously involved with the denial may answer questions. (10-16-113)		reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within five (5) calendar days. C. If the peer-to-peer conversation does not resolve the difference of opinion, the adverse determination may be appealed by the covered person. A peer-to-peer conversation is not a prerequisite to a first level review or an expedited review of an adverse determination. (3 CCR 702 Reg. 4-2-17 s 10)

CT	CT Gen Stat § 38a-472g		(A) Such insurer, center, society, corporation, entity or company failed to notify the insured's or enrollee's health care provider at least three business days prior to the scheduled date of such admission, service, procedure or extension of stay that such prior authorization or precertification has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage. (CT Gen Stat § 38a-472g)				

DE	18 Del.C. §§ 3373 and 72	(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health care provider within 2 business days of obtaining a clean pre-authorization or of using services described in § 3377 of this title. (18 § 3373) (c) If a utilization review entity requires pre-authorization of a health care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health care provider of the determination within 5 business		Clinical criteria shall be described in language easily understandable by a health care provider practicing in the same clinical area. (18 § 3372)			

		days of receipt of a clean pre-authorization through electronic pre-authorization. For purposes of this subsection, aclean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required. (18 § 3373)					

DC	DC Code §§31-3875.03; 31-3875.02; 31-3875.06	(a) If a utilization review entity requires prior authorization of a health care service, the utilization review entity shall, after receiving all required information to make its decision, make an approval or adverse determination and notify the enrollee, representative, and the enrollee's health care provider of its decision within: (1) For an urgent health care service, 24 hours; (2) For long-term services and supports, 30 days; provided, that the enrollee has been determined to be otherwise eligible for such benefits under Medicaid; and (3) For all other health care services, 3 business	(2) If a health care provider certifies in writing to a utilization review entity within 72 hours of an enrollee's receipt of an emergency health care service that the enrollee's condition required the provision of such service, the service shall be presumed to have been medically necessary and may be rebutted only if the utilization review entity establishes through clear and convincing evidence that the emergency health care service was not medically necessary. (31-3875.03)	(a)(1) A utilization review entity may only require prior authorization for a covered health care service based on a determination of medical necessity for different care or that the proposed care is experimental or investigational in nature. (31-3875.02)	(a)(1) A utilization review entity shall ensure that an adverse determination is made by a physician who: (A) Possesses a current and valid non-restricted license to practice medicine in the District, Maryland, or Virginia; and (B) Is of the same or similar specialty as a physician who typically manages the medical condition or disease or provides the health care service involved in the request; provided, that a physician making an adverse determination for pediatric care shall have a pediatric specialty. (2) The reviewing physician shall: (A) Be under the clinical direction of		(a) A utilization review entity shall provide an enrollee with at least 15 calendar days from the date the enrollee receives notice of an adverse determination to appeal the decision via the utilization review entity's website, facsimile, or mail; provided, that an appeal submitted by mail shall be considered timely if postmarked within 15 calendar days of the enrollee receiving notice. (31-3875.05) (b) An action by a utilization review entity that establishes a pattern or practice of repeated violations of this title, as determined by the Commissioner of the Department of Insurance and Securities Regulation, shall

		days of receiving the request via electronic portal or 5 business days of receiving the request via mail, telephone, or facsimile. (31-3875.03)			one of the utilization review entity's medical directors licensed in the District who is responsible for providing health care services to enrollees in the District; and (B) Not receive any financial incentive based on the number of adverse determinations made; except, that the utilization review entity may establish medically appropriate performance standards. (b)(1) A utilization entity shall ensure that all appeals are reviewed by a physician who: (A) Possesses a current and valid non-restricted license to practice medicine in the District, Maryland, or Virginia;		constitute a violation of the Insurance Trade and Economic Development Amendment Act of 2000, effective April 3, 2001 (D.C. Law 13-265; D.C. Official Code § 31-2231.01 et seq.). (31-3875.08) (2) Prior to issuing an adverse determination, the utilization review entity shall notify the enrollee's health care provider that the medical necessity of the health care service is being questioned and give the responsible physician an opportunity to provide additional information or clarification on the medical necessity of the health care service. (31-3875.03)

					(B) Is of the same or similar specialty as a physician who typically manages the medical condition or disease or provides the health care service involved in the request; provided, that the physician reviewing an appeal for pediatric care shall have a pediatric specialty and practiced that specialty for at least 5 years; and (C) Is knowledgeable of, and have experience providing, the health care service on appeal. (2) A physician reviewing an appeal shall not: (A) Receive any financial incentive based on the number of adverse determinations made or upheld on appeal; provided,		

					that the utilization review entity may establish medically appropriate performance standards; (B) Have been directly involved in making the adverse determination; and (C) Be subordinate of the physician who made the adverse determination. (31-3875.06)		
FL	F.S.A. § 627.42392						

GA	GA Code Ann. §§ 33-46-1 to 16; §§ 33-46-20 to 32	Effective January 1, 2022, until December 31, 2022, if an insurer requires prior authorization of a healthcare service, a private review agent or utilization review entity shall notify the covered person's healthcare provider, or such provider's appropriately qualified designee, of any prior authorization or adverse determination within 15 calendar days of obtaining all necessary information to make such authorization or adverse determination. Effective January 1, 2023, if an insurer requires prior authorization of a healthcare service, a private review agent or utilization review entity shall notify the covered person's healthcare provider, or such		(c) If there is a change in coverage of, or approval criteria for, a previously authorized healthcare service, the change in coverage or approval criteria shall not affect a covered person who received prior authorization before the effective date of such change for the remainder of the covered person's plan year so long as such person remains covered by the same insurer. (33-46-28) (15) "Medical necessity" or "medically necessary" means healthcare services that a prudent physician or other healthcare provider would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a manner that is: (A) In accordance with generally accepted	A private review agent or utilization review entity shall ensure that all appeals are reviewed by an appropriate healthcare provider who shall: (1) Possess a current and valid nonrestricted license or maintain other appropriate legal authorization; (2) Be currently in active practice in the same or similar specialty and who typically manages the medical condition or disease; (3) Be knowledgeable of, and have experience providing, the healthcare service under appeal; (4) Not have been directly involved in making the adverse determination; and	Prior authorization shall not be required for unanticipated emergency healthcare services, urgent healthcare services, or covered healthcare services which are incidental to the primary covered healthcare service and determined by the covered person's physician or dentist to be medically necessary. (33-46-24) An insurer cannot require prior authorization for emergency prehospital ambulance transportation or for the provision of emergency	

		provider's appropriately qualified designee, of any prior authorization or adverse determination within 7 calendar days of obtaining all necessary information to make such authorization or adverse determination. (33-46-26) A private review agent or utilization review entity shall render a prior authorization or adverse determination concerning urgent healthcare services and notify such person's healthcare provider, or such provider's appropriately qualified designee, of that prior authorization or adverse determination no later than 72 hours after receiving all information needed		standards of medical or other healthcare practice; (B) Clinically appropriate in terms of type, frequency, extent, site, and duration; (C) Not primarily for the economic benefit of the health insurer or for the convenience of the patient, treating physician, or other healthcare provider; and (D) Not primarily custodial care, unless custodial care is a covered service or benefit under the covered person's healthcare plan. (33-46-4) (c) A private review agent or utilization review entity shall use documented clinical criteria that are based on sound clinical evidence and which are evaluated periodically to assure	(5) Consider all known clinical aspects of the healthcare service under review, including, but not limited to, a review of all pertinent medical or other records provided to the private review agent or utilization review entity by the covered person's healthcare provider, any relevant records provided to such agent or entity by a facility, and any medical or other literature provided to such agent or entity by the healthcare provider. (33-46-22)	healthcare services. (33-46-25)	

		to complete the review of the requested healthcare services. (33-46-27)		ongoing efficacy. (33-46-21			

HI	HB 954 Introduced January 21, 2025	(7)(a) A health care professional shall submit a prior authorization request for a non-urgent health care to the utilization review entity no later than five calendar days before the provision of the health care service. (b) A prior authorization request submitted pursuant to subsection (a) shall be deemed approved forty-eight hours after the submission of the request if the utilization review entity fails to: (1) Approve or deny the request and notify the enrollee or the enrollee's health care provider; (2) Request the health care provider for all additional information needed to render a decision; or (3) Notify the health	(11)(a) A utilization review entity shall not revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five business days from the date the health care provider received the prior authorization. (b) A utilization review entity shall pay a health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization unless: (1) The health care provider knowingly and materially misrepresented	(3)(a) A utilization review entity shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public, including the written clinical criteria; provided that requirements shall be described in detail but also in easily understandable language. (b) A utilization review entity that intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction shall: (1) Ensure that the new or amended requirement or restriction is not implemented until the utilization review entity's website has been updated to reflect the new or amended requirement	(4)(a) A utilization review entity shall ensure that all appeals are reviewed by a physician who: (1) Possesses a current and valid non-restricted license issued pursuant to chapter 453; (2) Is, and has been, in active practice for at least five consecutive years in the same or similar specialty as a physician who typically manages the medical condition or disease; (3) Is knowledgeable of, and has experience providing, the health care services under appeal; (4) Is not employed by a utilization review entity or be under contract with the utilization review entity other than to participate in one or more of the utilization	(9)(a) No utilization review entity shall require prior authorization for pre-hospital transportation or the provision of emergency health care services.	5. Adverse determination; notice and discussion required. Any utilization review entity questioning the medical necessity of a health care service shall notify the enrollee's physician that medical necessity is being questioned. Before issuing an adverse determination, the enrollee's physician shall have the opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining authorization of the health care service under review.

		care provider that prior authorization is being questioned for medical necessity, within the forty-eight-hour period. The utilization review entity shall have an additional twenty-four hours to process the request from the time the health care provider submits the additional information requested pursuant to paragraph (2). (c) Any health care provider who fails to submit the information requested pursuant to subsection (b)(2) within twenty-four hours shall submit a new prior authorization request.	the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity; (2) The health care service was no longer a covered benefit on the day it was provided; (3) The health care provider was no longer contracted with the patients' health insurance plan on the date the care was provided; (4) The health care provider failed to meet the utilization review entity's timely filing requirements; (5) The utilization	or restriction; and (2) Provide contracted health care providers of enrollees with written notice of the new or amended requirement or amendment no later than sixty days before the implementation of the requirement or restriction.	review entity's health care provider networks or to perform reviews of appeals, and otherwise does not have any financial interest in the outcome of the appeal; and (5) Was not directly involved in making the adverse determination.		

			review entity is not liable for the claim; or (6) The patient was no longer eligible for health care coverage on the day the health care was provided.				

ID	41-3930	(2) If emergency services are offered, no managed care organization shall require prior authorization for emergency services. In addition, a managed care organization shall respond to member or provider requests for prior authorization of a nonemergency service within two (2) business days after complete member medical information is provided to the managed care organization unless exceptional circumstances warrant a longer period to evaluate a request. (41-3930)	(3) When prior approval for a covered service is required of and obtained by or on behalf of a member, the approval shall be final and may not be rescinded by the managed care organization after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits or if the member for whom the prior approval was granted is not enrolled at the time the covered service was provided. (41-3930)				

IL	215 ILCS 134/10	(c)The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. (215 ILCS 134/45) (a) Notwithstanding any other provision of law, a health insurance issuer or its contracted utilization review organization must render an approval or adverse determination concerning urgent 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 required by law, but not later than 48 hours after receiving all information needed to complete the review of the requested	(e) A health insurance issuer or its contracted utilization review organization 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. (215 ILCS 200/20)	(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. (215 ILCS 200/20) "Medically necessary" means that a service	A health insurance issuer or its contracted utilization review organization 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 in the same or similar specialty as a physician who typically manages the medical condition or disease; (3) be knowledgeable of, and have experience providing, the health care services under appeal;	A health insurance issuer shall periodically review its prior authorization requirements and consider removal of prior authorization requirements: (1) 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 (2) for patients currently managed with an established treatment regimen. (215 ILCS 200/50)	

		health care services. (215 ILCS 200/30) Notwithstanding any other provision of law, if a health insurance issuer requires prior authorization of a health care service, the health insurance issuer or its contracted utilization review organization 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 required by applicable law, but no later than 5 calendar days after obtaining all necessary information to make the approval or adverse determination. (215 ILCS 200/25)		or product addresses the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities, in a manner that is all of the following: (1) in accordance with generally accepted standards of care; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the economic benefit of the health care plan, purchaser, or utilization review organization, or for the convenience of the patient, treating physician, or other	(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 or its contracted utilization review organization by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer or its contracted utilization review organization by the health care professional or health care provider. (215 ILCS 200/45)		

				health care provider. (215 ILCS 134/10)			

IN	27-1-37.5-1 to 17	(b)(2) If the request is for an urgent care situation, the health plan shall respond with a prior authorization determination not more than forty-eight (48) hours after receiving the request. (b)(3) If the request is for a nonurgent care situation, the health plan shall respond with a prior authorization determination not more than five (5) business days after receiving the request. (27-1-37.5-11) (c)(2) if the request is incomplete, and was delivered under section 10(b) of this chapter, upon receiving the response under subdivision (1), the health care provider shall immediately send to the health plan an electronic receipt for the	(a) This section applies to a claim filed after December 31, 2018, for a medically necessary health care service rendered by a participating provider, the necessity of which: (1) is not anticipated at the time prior authorization is obtained for another health care service; and (2) is determined at the time the other health care service is rendered. (b) The health plan shall not deny a claim described in subsection (a) based solely on lack of prior authorization for the unanticipated health care service. (c) The			Prohibits prior authorization on list of CPT codes for state employee health plans. Study on impact by Nov 2025. Expires June 2026. (27-1-37.5-13.5)	(1) the health plan's clinical peer and the covered individual's health care provider or the health care provider's designee shall make every effort to provide the peer to peer review not later than seven (7) business days from the date of receipt by the health plan of the request by the covered individual's health care provider for a peer to peer review if the health plan has received the necessary information for the peer to peer review (27-1-37.5-17)

		response made under subdivision (1). (27-1-37.5-11)	health plan: (1) shall not deny payment for a health care service that is rendered in accordance with: (A) a prior authorization; and (B) all terms and conditions of the participating provider's agreement or contract with the health plan; and(2) may: (A) require retrospective review of; and (B) withhold payment for; an unanticipated health care service described in subsection (a). (27-1-37.5-13)				

IA	IAC 191-79.3 514F.8	79.3(5)Urgent claims. Prior authorization requests for urgent claims shall be approved or denied as soon as possible, but in no case later than 72 hours after receipt of the request. 79.3(6)Nonurgent claims. Prior authorization requests for nonurgent claims shall be approved or denied as soon as possible, but in no case later than five calendar days after receipt of the request. 79.3(7)Incomplete or additional information. If a request for a prescription drug prior authorization is incomplete or additional information is required, the health carrier, health benefit plan, or pharmacy benefits	b. A health carrier shall reimburse a health care provider at the contracted reimbursement rate for a health care service provided by the health care provider to a covered person per a prior authorization. c. Paragraphs "a" and "b" shall not apply in any of the following circumstances: (1) The health care provider or the covered person committed fraud, waste, or abuse. (2) The health care provider or the covered person provided inaccurate information			3. A prior authorization for a specific health care service for a covered person shall be valid for the specific health care service for not less than ninety days from the date that the covered person's health care provider receives the prior authorization from a utilization review organization, provided that during the ninety days the covered person remains a participant in the same health benefit plan in which the covered person participated on the date the prior authorization was received by	

		manager may request additional information within the applicable time periods provided in this rule. Once the additional information is submitted, the applicable time period for approval or denial shall begin again. 79.3(8)Prescription drug benefits provided by a qualified health plan. A QHP shall have procedures in place that comply with the health insurance issuer standards related to expedited review based on exigent circumstances and coverage determinations no later than 24 hours after receipt of requests as provided for in 45 CFR 156.122(c). (191-79.3)	that the utilization review organization relied on for the utilization review organization's prior authorization determination. (3) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the health care service was no longer a benefit covered by the covered person's health benefit plan. (4) On the date that the health care service was provided by the health care provider to the covered person per the			the health care provider. (514F.8)	

			prior authorization, the health care provider was no longer contracted with the health carrier that provides the covered person's health benefit plan. (5) The health care provider failed to meet the health carrier's requirements related to timely filing of claims for submission of a claim for the health care service provided by the health care provider to the covered person per the prior authorization. (6) Due to coordination of benefits, the health carrier does not have				

			liability for a claim for the health care service provided by the health care provider to the covered person per a prior authorization. (7) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the covered person was no longer a participant in the health benefit plan in which the covered person participated on the date that the prior authorization was received by the health care provider. (514F.8)				

KS	40-4603	(e) For required post evaluation or post stabilization services immediately following treatment of an emergency medical condition, a health insurer shall provide access to an authorized representative 24 hours a day, seven days a week.				(a) A health benefit plan shall not deny coverage for emergency services if the symptoms presented by an insured and recorded by the attending provider indicate that an emergency medical condition exists, or for emergency services necessary to provide an insured with a medical examination and stabilizing treatment, regardless of whether prior authorization was obtained to provide those services.	

KY	304.17A-600 to 633	(i)1. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision; and 2. If the insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within five (5) days of obtaining all necessary information to make the utilization review decision. (304.17A-607)	(1) A utilization review decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer or its designee for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider. (304.17A-611)	(35) "Medically necessary health care services" means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) In accordance with generally accepted standards of medical practice; and (b) Clinically appropriate in terms of type, frequency, extent, and duration. (304.17A-005)	(b) Ensure that, for any contract entered into on or after the effective date of this Act for the provision of utilization review services, only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, shall: 1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or		

		(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state; (f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays. (304.17A-607)			optometrist duly licensed in Kentucky; and 2. Supervise qualified personnel conducting case reviews. (304.17A-607)		

LA	R.S. 22:1260.41 to 48	B.(1) When an urgent condition request is made by the provider, the health insurance issuer shall electronically communicate its decision to the provider as soon as possible, but not more than two business days from receipt of the request. (R.S. 22:1260.44) (B)(2) For any requests from a provider for healthcare services requiring prior authorization for which the health insurance issuer does not receive a request for expedited review, the health insurance issuer shall communicate its decision on the prior authorization request no more than five business days from the receipt of the request.	A. A health insurance issuer shall not deny any claim subsequently submitted for healthcare services specifically included in a prior authorization unless at least one of the following circumstances applies for each healthcare service denied: (1) Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of prior authorization, have been reached due to utilization subsequent to the issuance of the prior authorization and the health insurance	(A) A health insurance issuer that requires the satisfaction of a utilization review as a condition of payment of a claim submitted by a healthcare provider shall maintain a documented prior authorization program that utilizes evidenced-based clinical review criteria. A health insurance issuer shall include a method for reviewing and updating clinical review criteria in its prior authorization program. (R.S. 22:1260.42) (D) Within seventy-two hours of receiving an oral or written request of a healthcare provider, a health insurance issuer shall provide to the healthcare provider the specific clinical review criteria used by the health insurance issuer to make its utilization review determination for the specific item or service.	C.(1) If a health insurance issuer denies a request for utilization review and the healthcare provider requests a peer review of the determination to deny, the health insurance issuer shall appoint a licensed healthcare practitioner similar in education and background or a same-or-similar specialist to conduct the peer review with the requesting provider. To be considered a same-or-similar specialist, the reviewing specialist's training and experience shall meet the following criteria: (a) Treating the condition. (b) Treating complications that may result from the service or procedure. (R.S. 22:1260.46)	A health insurance issuer shall not impose any additional utilization review requirement with respect to any surgical procedure or otherwise invasive procedure, nor any item furnished as part of such surgical or invasive procedure, if such procedure or item is furnished during the perioperative period of a procedure and either of the following conditions is met: (1) Prior authorization was received by the healthcare provider from the health	(3) When the peer review is requested by a physician, the health insurance issuer shall appoint a physician to conduct the review. The health insurance issuer shall notify the physician of its peer review determination within two business days of the date of the peer review. (R.S. 22:1260.46)

		(R.S. 22:1260.44) C.(1) For concurrent review determinations, a health insurance issuer or utilization review entity shall make the determination within twenty-four hours of obtaining all necessary information from the provider or facility. (R.S. 22:1260.44) D. For retrospective review determinations, a health insurance issuer shall make the determination within thirty business days of receiving all necessary information. A health insurance issuer shall provide notice of the determination in writing to the enrollee and provider within three business days of making the	issuer provides notification to the provider prior to healthcare services being rendered. (2) The documentation for the claim provided by the provider clearly fails to support the claim as originally certified. (3) If, subsequent to the issuance of the prior authorization, new services are provided to the enrollee or a change in the enrollee's condition occurs indicating that the prior authorized service would no longer be considered medically necessary,	(R.S. 22:1260.42) E.(1) A health insurance issuer shall maintain a system of documenting information and supporting clinical documentation submitted by healthcare providers seeking utilization review. (2) A health insurance issuer shall provide a unique confirmation number to a healthcare provider upon receipt from that provider of a request for utilization review. (R.S. 22:1260.42)		insurance issuer before the surgical procedure or item, as part of such surgical or otherwise invasive procedure, was furnished. (2) Prior authorization was not required by the health insurance issuer. (R.S. 22:1260.43)	

		retrospective review determination. (R.S. 22:1260.44) (F) The health insurance issuer has one calendar day to inform the provider of the particular additional information necessary to make the determination, and shall allow the provider at least two business days to provide the necessary information to the health insurance issuer. In cases where the provider or an enrollee will not release necessary information, the health insurance issuer may deny certification of an admission, procedure, or service. (R.S. 22:1260.44)	based on the prevailing standard of care. (4) If, subsequent to the issuance of the prior authorization, new services are provided to the enrollee or a change in the enrollee's condition occurs indicating that the prior authorized service would at that time require disapproval in accordance with the terms and conditions for coverage under the enrollee's plan in effect at the time the prior authorization was certified. (5) The health insurance issuer's denial				

			is due to one of the following: (a) Another payor is responsible for the payment. (b) The healthcare provider has already been paid for the healthcare services identified on the claim. (c) The claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the health insurance issuer by the healthcare provider, enrollee, or the enrollee's representative.				

			(d) The person receiving the service was not eligible to receive the healthcare service on the date of service and the health insurance issuer did not know and, with the exercise of reasonable care, could not have known of the person's ineligibility status. B. A health insurance issuer's certification of prior authorization is valid for a minimum of three months. (R.S. 22:1260.47)				

ME	M.R.S.A. 24-A § 4304 Insurance Rule Ch. 850 § 8	(2) Prior authorization of nonemergency services. Except for a request in exigent circumstances as described in section 4311, subsection 1-A, paragraph B, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection. (24-A § 4304) C. If the carrier responds that outside consultation is necessary before making a decision, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier's initial response. (24-A § 4304)	(4) Revocation of prior authorization. When prior approval for a service or other covered item is granted, a carrier may not retrospectively deny coverage or payment for the originally approved service unless fraudulent or materially incorrect information was provided at the time prior approval for the service was granted. (24-A § 4304)	(D)(1) A utilization review program shall use documented clinical review criteria that are based on published sound clinical evidence and which are evaluated periodically to assure ongoing efficacy. A health carrier or the carrier's designated URE may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors. Upon request, a health carrier or the carrier's designated URE shall make available its clinical review criteria to the Superintendent and the Commissioner of the Department of Human Services. (Insurance Rule Ch. 850 § 8)	(7) An appeal of a carrier's adverse health care treatment decision must be conducted by a clinical peer. The clinical peer may not have been involved in making the initial adverse health care treatment decision unless additional information not previously considered during the initial review is provided on appeal. (24-A § 4304)	1. Prior authorization for new episode of care prohibited for 12 visits. A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care. For purposes of this subsection, “new episode of care” means treatment for a new condition or treatment for a recurring condition for which an enrollee has not been treated	

						within the previous 90 days. 2. Intent. This section does not limit the right of a carrier to deny a claim when an appropriate prospective or retrospective review concludes that the health care services or treatment rendered were not medically necessary. (24-A § 4304-A)	

MD	Health - General § 19-108.2	(3)(i) In real time, electronic preauthorization requests for pharmaceutical services: 1. For which no additional information is needed by the payor to process the preauthorization request; and 2. That meet the payor's criteria for approval; (ii) Within 1 business day after receiving all pertinent information on requests not approved in real time, electronic preauthorization requests for pharmaceutical services that: 1. Are not urgent; and) 2. Do not meet the standards for real-time approval under					

		item (i) of this item; and (iii) Within 2 business days after receiving all pertinent information, electronic preauthorization requests for health care services, except pharmaceutical services, that are not urgent. (Health - General s 19-108.2)					

MA	176O:25 958 CMR 3.101	(b) If a payer or any entity acting for a payer under contract fails to use or accept the required prior authorization form, or fails to respond within 2 business days after receiving a completed prior authorization request from a provider, pursuant to the submission of the prior authorization form developed as described in subsection (c), the prior authorization request shall be deemed to have been granted. (176O:25)		(1) A carrier may develop guidelines to be used by the carrier in determining if services are medically necessary. Any such guidelines used by a carrier in determining if covered services are medically necessary shall be, at a minimum: (a) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (b) developed in accordance with standards adopted by national accreditation organizations; (c) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice;			

				(d) evidence based, if practicable; (e) applied in a manner that considers the individual health care needs of the insured; (f) prior to implementation of any new or amended guidelines to be effective on or after April 28,2023, assessed by the carrier or utilization review organization to show compliance with state and federal parity requirements as required by the Division of Insurance under M.G.L. c. 26, § 8K; and (g) otherwise compliant with applicable state and federal law. (958 CMR 3.101)			

MI	MI ST. § 500.2212 e	(10) A prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 7 calendar days after the date and time of submission of the prior authorization. (500.2212e) (11) A prior authorization request under this section that has been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization		The prior authorization requirements must be based on peer-reviewed clinical review criteria. All of the following apply to clinical review criteria under this subsection: (a) Unless the criteria are developed as described in subdivision (g), the clinical review criteria must be criteria developed by either of the following: (i) An entity to which both of the following apply: (A) The entity works directly with clinicians, either within the organization or outside the organization, to develop the clinical review criteria. (B) The entity does not receive direct payments based on the outcome of the clinical care decision. (ii) A professional medical specialty	(9) An insurer or its designee utilization review organization shall not affirm the denial of an appeal under subsection (8) unless the appeal is reviewed by a licensed physician who is board certified or eligible in the same specialty as a health care provider who typically manages the medical condition or disease or provides the health care service. However, if an insurer or its designee utilization review organization cannot identify a licensed physician who meets the requirements described in this subsection without exceeding the applicable time limits imposed under subsection (10), the insurer or its designee utilization review organization may	(16) An insurer described in subsection (1) shall adopt a program, developed in consultation with health care providers participating with the insurer, that promotes the modification of prior authorization requirements of certain prescription drugs, medical care, or related benefits, based on any of the following: (a) The performance of health care providers with respect to adherence to nationally recognized evidence-based medical guidelines, appropriatenes s, efficiency, and other	

		if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 72 hours after the date and time of submission of the prior authorization request. (500.2212e)		society. (b) The clinical review criteria must take into account the needs of atypical patient populations and diagnoses. (c) The clinical review criteria must ensure quality of care and access to needed health care services. (d) The clinical review criteria must be evidence-based criteria. (e) The clinical review criteria must be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis. (f) The clinical review criteria must be evaluated and updated, if necessary, at least annually. (500.2212e)	utilize a licensed physician in a similar specialty as considered appropriate, as determined by the insurer or its designee utilization review organization. (500.2212e)	quality criteria. (b) Involvement of contracted health care providers with an insurer described in subsection (1) to participate in a financial risk-sharing payment plan, that includes downside risk. (c) Health provider specialty, experience, or other factors. (500.2212e)	

MN	M.S.A. § 62M.01 to 19	Subd. 3a. Standard review determination. (a) A standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization. (62M.05) Subd. 3b. (a) An expedited determination must be utilized if the attending health care professional believes that an expedited	Subd. 3. Retrospective revocation or limitation of prior authorization. No utilization review organization, health plan company, or claims administrator may revoke, limit, condition, or restrict a prior authorization that has been authorized unless there is evidence that the prior authorization was authorized based on fraud or misinformation or a previously approved prior authorization conflicts with state or federal law. Application of a deductible, coinsurance, or other cost-	If no independently developed evidence-based standards exist for a particular treatment, testing, or imaging procedure, then an insurer or utilization review organization shall not deny coverage of the treatment, testing, or imaging based solely on the grounds that the treatment, testing, or imaging does not meet an evidence-based standard. This section does not prohibit an insurer or utilization review organization from denying coverage for services that are investigational, experimental, or not medically necessary. (62M.072) Subd. 5. Written clinical criteria. A utilization review organization's decisions must be supported by written clinical criteria and review procedures. Clinical criteria and review procedures	(3)(g) In cases of appeal to reverse an adverse determination for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case. (62M.06) No individual who is performing utilization review may receive any financial incentive based on the number of adverse determinations made by such individual, provided that utilization review organizations may		

		determination is warranted. (b) Notification of an expedited determination to authorize or an expedited adverse determination must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 48 hours and must include at least one business day after the initial request. (62M.05) (b) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 15 days after receipt of the notice of appeal. If the utilization review	sharing requirement does not constitute a limit, condition, or restriction under this subdivision. (62M.07)	must be established with appropriate involvement from actively practicing physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the authorization request. The utilization review organization must have a procedure for ensuring, at a minimum, the annual evaluation and updating of the written criteria based on sound clinical principles. (62M.09)	establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health plan companies and providers. (62M.12)		

		organization cannot make a determination within 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to four additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. (62M.05)					

MS	M.S. Code § 83-9-6.3	(3) A health insurance issuer shall respond within two (2) business days upon receipt of a completed prior authorization request from a prescribing provider that was submitted using the standardized prior authorization form required by subsection (2) of this section. (83-9-63)					

MO	Mo. Rev. Stat.§§ 376.1350-376.1389; SB 982	(2)(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the certification; 3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information. (376.1363)	1. The director shall resolve any grievance regarding an adverse determination as to covered services appealed by an enrollee or health carrier or plan sponsor through any means not specifically prohibited by law but if the grievance is unresolved by the director then it shall be resolved by referral of such grievance to an independent review organization. The director shall establish the qualifications for such review panel(s) and shall seek the services of such organization(s) by competitive	1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request by either the director of the department of health and senior services or the director of the department of insurance. 8. When conducting utilization review, the health carrier shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services. (376.1361)	2. Any medical director who administers the utilization review program or oversees the review decisions shall be a qualified health care professional licensed in the state of Missouri. A licensed clinical peer shall evaluate the clinical appropriateness of adverse determinations. (376.1361) 9. Compensation to persons providing utilization review services for a health carrier shall not contain direct or indirect incentives for such persons to make medically inappropriate review decisions. Compensation to any such persons may not be directly or indirectly based on the quantity or type of adverse determinations		3. Review by the grievance advisory panel shall follow the same time frames as a first level review, except as provided for in section 376.1389 if applicable. Any decision of the grievance advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office. (376.1385)

			bid pursuant to chapter 34, RSMo. The director shall enter into contracts with such organization(s) as deemed necessary to conduct the adverse determination appeals process set forth in this section. Any request for an adverse determination appeal shall be assigned on a rotational basis. The organization's decision as to the resolution of the grievance shall be based upon a review of the written record before it. The grievance and resolution of such grievance shall not be considered a	(2) A health benefit plan that provides coverage for drugs shall provide coverage for any drug prescribed to treat an indication so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate. (376.1361)	rendered. (376.1361)		

			contested case within the meaning of section 536.010, RSMo, but the resolution of such grievance by the panel shall be considered a final agency decision within the director's discretion, binding upon the enrollee and health carrier, and subject to judicial review if: (1) Action for such review is filed within thirty days of the final agency decision; and (2) Judicial review is limited to the record before the director; and (3) The enrollee				

			and health carrier are deemed real parties in interest; and (4) The scope of judicial review extends only to a determination of whether the action of the director is unconstitutional, unlawful, unreasonable, arbitrary, or capricious or involves an abuse of discretion or is in excess of the statutory authority or jurisdiction of the director. 2. Nothing in this section is intended to restrict the director's authority to investigate and resolve any complaint against a health carrier that				

			does not constitute a grievance within the meaning of section 376.1350. 3. Any grievance involving coverage provided pursuant to a Medicaid program, however, shall be resolved in accordance with the rules and procedures established for the Medicaid program. (376.1387)				

MT	MT ST. §§ 33-32-101 to 419	(1) Within 120 days after the date of receipt of a notice of an adverse determination or a final adverse determination pursuant to 33-32-403, a covered person or, if applicable, the covered person's authorized representative may file a request for an external review with the health insurance issuer. (2) Within 5 business days after the date of receipt of the external review request, the health insurance issuer shall complete a preliminary review of the request to determine whether: (a) the individual is or was a covered person in the health plan at the time the health care service or treatment was requested or, in the		(21) "Medical necessity" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are: (a) in accordance with generally accepted standards of practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or	(2) Any adverse determination for a prescription drug made during prior authorization by a health insurance issuer must be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination does not require the involvement of a physician on the part of a health insurance issuer. (SB 380)(2023)	(1) A health insurance issuer may not perform prior authorization on benefits for: (a) any generic prescription drug that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32, after a covered person has been prescribed the covered drug at the same quantity without interruption for 6 months; (b) any prescription drug or drugs, generic or	(1) Except as specified in 33-32-309, a health insurance issuer shall use written procedures for receiving and resolving grievances from covered persons as provided in 33-32-308. (2)(a) Whenever a health insurance issuer fails to adhere to the requirements of 33-32-308 or 33-32-309, as applicable, with respect to receiving and resolving grievances involving an adverse determination or waives the review of the grievance, the covered person is considered to have exhausted the provisions of this part and may take action under subsection (2)(b). (b)(i) A covered person may file a request for external review in

		case of a retrospective review, was a covered person in the health plan at the time the health care service or treatment was provided; (b) the health care service or treatment that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health plan but is not covered because of a determination by the health insurance issuer that the health care service or treatment does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness;		sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.		brand name, on the grounds of therapeutic duplication for the same drug if the covered person has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the prescription drug or drugs was approved; (c) any prescription drug, generic or brand name, solely because the dosage of the medication for the covered person has been adjusted by the prescriber of the prescription drug, as long as the dosage is within the	accordance with the procedures outlined in Title 33, chapter 32, part 4. (ii) In addition to filing a request under subsection (2)(b)(i), a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health insurance issuer failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. (3)(a) The provisions of 33-32-308 or 33-32-309 may not be considered exhausted based on a de minimis violation that does not cause and is not likely to cause prejudice or harm to the covered person as long as the health insurance issuer demonstrates that

		(c) the covered person has exhausted the health insurance issuer's internal grievance process as set forth in Title 33, chapter 32, part 3, or the covered person is exempt under 33-32-307(2); and (d) the covered person or the covered person's authorized representative has provided all of the information and forms required to process an external review.				dosage approved by the food and drug administration or is consistent with clinical dosing for the medication; or (d) any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic. (SB 380)(2023)	the violation was for good cause or due to matters beyond the control of the health insurance issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative. (b) The exception provided in subsection (3)(a) does not apply if the violation is part of a pattern or a practice of violations by the health insurance issuer. (33-32-307)

NE	NE ST. §§ 44-5401 to 5431			A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies. (44-5426)	44-5422 (f) During a final appeal of a decision not to certify or approve for clinical reasons, a utilization review agent shall assure that a physician is reasonably available to review the case, except that if the health care services were provided or authorized by a provider other than a physician, such appeal may be reviewed by a nonphysician provider whose scope of practice includes the treatment or services. Hospitals, health care providers, or representatives of the covered person may assist in an appeal. (44-5422)		44-5427 (3) A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions. (44-5427)

NV	NV ST.§§ 687B.225; 616C.157; 683A.372	1. An insurer, organization for managed care or third-party administrator shall respond to a written request for prior authorization for: (a) Treatment; (b) Diagnostic testing; or (c) Consultation, within 5 working days after receiving the written request. 2. If the insurer, organization for managed care or third-party administrator fails to respond to such a request within 5 working days, authorization shall be deemed to be given. The insurer, organization for managed care or third-party administrator may subsequently deny authorization. (616C.157) (b) Unless a shorter time period is prescribed by a specific statute,		1. To be approved under NRS 683A.3715 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process which include, without limitation: (a) A quality assurance mechanism which ensures: (1) That an external review is conducted within the specified time frames and required notices are provided in a timely manner; (2) The selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization, suitable matching of reviewers to specific cases and that the independent review organization employs	2. A clinical reviewer assigned by an independent review organization to conduct an external review must be a physician or other appropriate health care provider who must: (a) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review; (b) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition as the covered person; (c) Hold a nonrestricted license in a state or territory of the United States and, if a physician, hold a current certification by a specialty board		

		including, without limitation, sections 17, 19, 20, 22, 23, 24 and 27 of this act, respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request. (687B.225)		or contracts with an adequate number of clinical reviewers to meet this requirement; (3) The confidentiality of medical and treatment records and clinical review criteria; and (4) That a person employed by or under contract with the independent review organization adheres to the requirements of the external review process (683A.372)	of the American Board of Medical Specialties in the area or areas appropriate to the subject of the external review; and (d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character. (683A.372)		

NH	NHRSA §§ 420-J: 5, 420-7-b; 415-A:4-a; 415-A:4-b	Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary nonformulary prescription drug or for a nonformulary prescription drug that was available during the previous 12 months. (420-J:7-b) In the appeal of a claim for urgent care . . . an expedited appeal process shall be made providing for . . . (b) The determination of the appeal not more than 72 hours after the submission of the request for appeal. (420-J:5)		(b) Clinical review criteria considered or utilized in making claim benefit determinations shall be: (1) Developed with input from appropriate practitioners with professional knowledge or clinical expertise in the area being reviewed; (2) Updated at least biennially and as new treatments, applications, and technologies emerge; (3) Developed in accordance with the standards of national accreditation entities; (4) Based on current, nationally accepted standards of medical practice; and (5) If practicable, evidence-based. (415-A:4-a)		No health benefit plan shall require a prior authorization for medically necessary interfacility transports for services related to the treatment and diagnosis of certain biologically-based mental illnesses. (417-F:3) Whenever substance use disorder services are a covered benefit under a health benefit plan subject to this chapter, a health carrier shall: I. Be required to offer at least one medication-assisted treatment therapy option approved by the	(a) The determination of a claim involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after receipt of the claim, unless the claimant or claimant's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such failure, the licensee shall notify the claimant or claimant's representative within 24 hours of receipt of the claim and shall advise the claimant or claimant's representative of the specific information necessary to determine the claim. The claimant or the claimant's representative shall

		If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the covered person until the covered person has been notified of the determination. A carrier or other licensed entity shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing. (420-J:5) (a) In non-urgent circumstances, health carriers requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the				federal Food and Drug Administration for treatment of substance use disorders without a requirement for prior authorization. II. Not require a renewal of a prior authorization for a medication-assisted treatment therapy for treatment of substance use disorders more frequently than once every 12 months. (420-J:18)	be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than 48 hours after the earlier of (1) the licensee's receipt of the specified additional information, or (2) the end of the period afforded the claimant or claimant's representative to provide the specified additional information. (415-A:4-a)

		determination within 14 calendar days of obtaining all information necessary to make the determination. Any request that the health carrier makes for additional information necessary to make the determination shall be made within 7 calendar days of the prior authorization request date. (420-J:6)					

NJ	NJ Uncodified AB 1255	(a) A carrier shall respond to prior authorization requests for medication coverage submitted using the NCPDP SCRIPT Standard for ePA (electronic prior authorization) transactions, under the pharmacy benefit part of a health benefits plan, within 24 hours for urgent requests and 72 hours for non-urgent requests after obtaining all necessary information to make the approval or adverse determination. (NJ Uncodified AB 1255 s 7) (a)(2) in the case of a request for prior authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a	(a) On receipt of information documenting a prior authorization from the covered person or the health care provider of the covered person, a payer shall honor a prior authorization granted to a covered person by a previous payer for at least the initial 60 days of coverage under a new health plan of the covered person, if that prior authorization was based on information provided in good faith by a provider. (NJ Uncodified AB 1255 s 11) (a) A payer shall reimburse a hospital or	"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results	Any denial of a request for prior authorization or limitation imposed by a payer on a requested service on the basis of utilization management determination shall be made by a physician who shall: a. make the adverse determination under the clinical direction of a medical director of the payer who shall: (1) be licensed in this State; and (2) strictly follow a medical policy that has been developed and made available in accordance with P.L., c. (C.) (pending before the Legislature as this bill) and the "New Jersey Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.); b. not be compensated by a payer based on the approval or denial rate of the reviewing		A payer found in violation of those sections shall be liable for a civil penalty of not more than $10,000 for each day that the payer is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation and fails to do so within the time allowed. (NJ Uncodified AB 1255 s 16)

		hospital, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or health care provider within a time frame appropriate to the medical exigencies of the case but no later than 24 hours. (NJ Uncodified AB 1255 s 12) (4) in the case of a claim involving urgent care, the payer shall notify the hospital or health care provider of the carrier's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the carrier, unless the hospital or health care provider fails to provide sufficient information to	health care provider according to the provider contract for all medically necessary emergency and urgent care health care services that are covered under the health benefits plan, including all tests necessary to determine the nature of an illness or injury; pre-hospital transportation; or the provision of emergency health care services. (NJ Uncodified AB 1255 s 15)	as to the diagnosis or treatment of that covered person's illness, injury, or disease. (NJ Uncodified AB 1255 s 4)	physician; and c. not be provided preferential treatment by a payer in the requests for prior authorization of the reviewing physician if that physician is also a network provider for the payer. (NJ Uncodified AB 1255 s 9) A payer shall ensure that any adverse determinations of any appeal are reviewed by a physician. The physician shall: a. be board certified in a same or similar specialty that has experience treating the condition or service under review or has experience treating the condition within the last five years; b. not be paid by a payer based on the reviewing physician's denial or approval rate; c. not have been		

		determine whether, or to what extent, benefits are covered or payable under the plan. (NJ Uncodified AB 1255 s 12) (e) If a covered person receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a payer shall make an authorization determination within 150 minutes of receiving a request. If the authorization determination is not made within 150 minutes, those services shall be deemed approved. (NJ Uncodified AB 1255 s 15)			directly involved in making an initial adverse determination for the same claim; d. 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 payer by the health care provider of the covered person, any relevant records provided to the payer by a health care facility, and any medical literature provided to the payer by the health care service provider of the covered person; e. not be provided preferential treatment by the payer in the reviewing physician's own requests for prior authorization if the reviewing physician is also a network		

					provider; and f. when requested by the treating provider, engage in a telephonic conversation with the treating provider to discuss the need for the prescribed medication or service. (NJ Uncodified AB 1255 s 13)		

NM	59A-22B-5	B. Prior authorization shall be deemed granted for determinations not made within seven days; provided that: (1) an adjudication shall be made within twenty-four hours, or shall be deemed granted if not made within twenty-four hours, when a covered person's health care professional requests an expedited prior authorization and submits to the health insurer a statement that, in the health care professional's opinion that is based on reasonable medical probability, delay in the treatment for which prior authorization is requested could result in permanent harm.					

NY	N.Y. Ins. Law §§ 4902; 4903;4904	(c)A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the insured of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within thirty days of the receipt of necessary information to conduct the appeal and, upon overturning the adverse decision, shall comply with subsection (a) of section three		(9) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.	(a)(3) A clinical peer reviewer where the review involves an adverse determination. (4903) (d) Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. (4904)		(b)Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. (4904) The notice of the appeal determination shall include: (1) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal,

		thousand two hundred twenty-four-a of this chapter as applicable. (4904) (b)The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use disorder treatment provided pursuant to paragraph three of subsection (c) of section four thousand nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such		(4902) (12) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen. (4902)			the notice shall include the clinical rationale for such determination; and (4904)

		appeal. (4904) (c-1) A utilization review agent shall grant a step therapy protocol override determination within seventy-two hours of the receipt of informationc-1) A utilization review agent shall grant a step therapy protocol override determination within seventy-two hours of the receipt of information (4903) (c-2) For an insured with a medical condition that places the health of the insured in serious jeopardy without the prescription drug or drugs prescribed by the insured's health care professional, the step therapy protocol override determination shall be granted within twenty-four hours of the receipt of					

		information that includes supporting rationale and documentation from a health care professional demonstrating one or more of the standards provided for in subsection (c-1) of this section. (4903) (6)(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subsection (a) of section four thousand nine hundred three of this title or an expedited appeal filed pursuant to subsection (b) of section four					

		thousand nine hundred four of this title, on a twenty-four hour a day, seven day a week basis; (4902)					

NC	N.C Gen. Stat.§§ 58-50-61; 58-3-200	(e)(6)(f) Prospective and Concurrent Reviews. — As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider	(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan, plan or dental plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination,		(d) Program Operations. — In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its		(m) Disclosure Requirements. — In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the

		and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification. (58-50-61)	unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item. For purposes of this subsection, apretreatment estimate means a voluntary request for a projection of dental benefits or payment that does not require authorization and a pretreatment estimate for dental services shall not be considered a coverage determination. (58-3-200(c))		URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers		Program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes. (58-50-61) (o) Violation. — A violation of this section subjects an insurer to G.S. 58-2-70, (civil liability). (58-50-61)

					shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section. (58-50-61)		

ND	SB 2389 (2023)						1. During the 2023-24 interim, the legislative management shall consider studying prior authorization in health benefit plans. The study must include consideration of: a. The extent to which prior authorization is used by health insurance companies in this state, including the types of services and procedures for which prior authorization is required. b. The impact of prior authorization on patient care, including the effects on patient health outcomes, patient satisfaction, health care costs, and patient access to care. c. The impact of prior authorization on health care providers and insurers, including

							the administrative burden, time, and cost associated with obtaining prior authorization, and the appropriate utilization of health care services. d. State and federal laws and regulations that may impact prior authorization. e. Input from stakeholders, including patients, providers, and commercial insurance plans. 2. The study may include consideration of issues related to response times, retroactive denial, data reporting, clinical criteria and medical necessity, transparency, fraud and abuse, reviewer qualifications, exceptions, and an appeal process. 3. The legislative management shall report its findings and

							recommendations, together with any legislation required to implement the recommendations, to the sixty-ninth legislative assembly (SB 2389)

OH	Ohio Rev. Code § 1751.72	(4)(a) For policies issued on or after January 1, 2018, if the health care practitioner submits the request for prior authorization as described in divisions (B)(1) and (2) of this section, the health insuring corporation shall respond to all prior authorization requests within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received by the health insuring corporation. Division (B)(4) of this section does not apply to emergency services. (1751.72) (12) For policies issued on or after January 1, 2018, the	(9)(a) For policies issued on or after January 1, 2017, upon written request, a health insuring corporation shall permit a retrospective review for a claim that is submitted for a service where prior authorization was required but not obtained if the service in question meets all of the following: (i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed. (ii) The new		(c) The appeal shall be between the health care practitioner requesting the service in question and a clinical peer. (1751.72)		(E) For policies issued on or after January 1, 2017, committing a series of violations of this section that, taken together, constitute a practice or pattern shall be considered an unfair and deceptive practice under sections 3901.19 to 3901.26 of the Revised Code. (1751.72) (12)(d) If the appeal does not resolve the disagreement, either the covered person or an authorized representative as defined in section 3922.01 of the Revised Code may request an external review under Chapter 3922. of the Revised Code to the extent Chapter 3922. of the Revised Code is applicable. (1751.72) (C)(5) If the health care practitioner

		health insuring corporation shall establish a streamlined appeal process relating to adverse prior authorization decision determinations that shall include all of the following: (a) For urgent care services, the appeal shall be considered within forty-eight hours after the health insuring corporation receives the appeal. (b) For all other matters, the appeal shall be considered within t en calendar days after the health insuring corporation receives the appeal. (1751.72)	service was not known to be needed at the time the original prior authorized service was performed. (iii) The need for the new service was revealed at the time the original authorized service was performed. (1751.72)				submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care practitioner in the approved prior authorization request, upon receiving a denial of services from the health insuring corporation, the health care practitioner may resubmit the claim pursuant to division (C) of this section with the information that matches the information included in the approved prior authorization. (1751.72)

OK	Okla. Stat. Tit. 36, § 6907			A. Every health maintenance organization shall establish procedures that ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care. (36 § 6907)			

OR	O.R.S. §§ 743B.001; 743B.256; 743B.420; 743B.423	(2)(i) Except as provided in paragraph (j) of this subsection, an insurer must issue a determination on a provider's or an enrollee's request for coverage of a nonemergency treatment, drug, device or diagnostic or laboratory test that is subject to utilization review within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. (2)(j) If the insurer requires additional information from an	Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements: (1) Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than 60 days prior to the date the service is provided. (2) Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days	(2)(a) In addition to the requirements of ORS 743B.602, in establishing utilization review, the insurer must use clinical review criteria that are evidence-based and continuously updated based on new evidence and research, and take into account new developments in treatment. (743B.423)	(2)(f) The insurer must use a physician licensed under ORS 677.100 to 677.228 to make all final recommendations regarding coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review and to consult as needed. (743B.423) (1) An independent review organization shall perform the following duties when appointed under ORS 743B.252 to review a dispute under a health benefit plan between an insurer and an enrollee: (b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization. At least one reviewer must be a clinician in the same or a	(13) "Managed health insurance" means any health benefit plan that: (a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service. (743B.001)	(h) The insurer must make available to any provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee. (743B.423)

		enrollee or a provider to make a determination on a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, no later than two business days after receipt of the request, the insurer shall notify the enrollee and the provider in writing of the additional information needed to make the determination. The insurer shall issue the determination by the later of: (A) Two business days after receipt of a response from the provider or enrollee to the request for additional information; or (B) Fifteen days after the date of the request for additional information (743B.423)	prior to the date the service is provided (743B.420)		similar specialty as the provider who prescribed the treatment that is under review. (743B.256)		

PA	PA Statutes 40 P.S.§§ 991.2154; 991.2155; 991.2161	(h) Review time lines for requests submitted to an MA or CHIP managed care plan. (1) An MA or CHIP managed care plan's decision to approve or deny a prior authorization request shall be communicated within two business days of the receipt of all supporting information reasonably necessary to complete the review. (2) If at any time after requesting prior authorization the provider determines the enrollee's medical condition requires emergency services, the emergency services may be provided under section 2116. (2155) (i)(1) For a request related to an urgent	(j) Closely related services.—If a health care provider performs a closely related service, an insurer or MA or CHIP managed care plan may not deny a claim for the closely related service for failure of the health care provider to seek or obtain prior authorization, if: (1) The health care provider notifies the insurer or MA or CHIP managed care plan of the performance of the closely related service no later than three business days following completion of the service but prior to the submission of	(a)(3) An insurer or MA or CHIP managed care plan shall review each adopted medical policy on at least an annual basis. (2154) (1) Clinical review criteria adopted by an insurer or MA or CHIP managed care plan shall, at the time of medical policy development or review: (i) Be based on applicable nationally recognized medical standards. (ii) Be consistent with applicable governmental guidelines. (iii) Provide for the delivery of a health care service in a clinically appropriate type, frequency and setting and for a clinically appropriate duration. (iv) Reflect the current medical and scientific	(d)(1)(i) a licensed health care provider with appropriate training, knowledge or experience in the same or similar specialty that typically manages or consults on the health care service in question; or (ii) a licensed health care provider, in consultation with an appropriately qualified third-party health care provider, licensed in the same or similar medical specialty as the requesting health care provider or type of health care provider that typically manages the covered person's or enrollee's associated condition. (2155) (c) A review conducted under this section shall include a licensed physician or, where appropriate, a		(e) Peer-to-peer review available.—In the case of a denied prior authorization request other than an administrative denial, an insurer or MA or CHIP managed care plan shall make available to the requesting provider a licensed health care professional for a peer-to-peer review discussion. The peer-to-peer reviewer provided by the insurer or MA or CHIP managed care plan shall meet the standards specified in subsection (d) and have authority to modify or overturn the prior authorization decision. The following shall apply: (1) The procedure for requesting a peer-to-peer review discussion, including contact

		health care service: (i) If the urgent health care service has not yet been initiated, as soon as possible, but not more than 72 hours. (ii) If related to an ongoing urgent health care service and the request is made at least 24 hours prior to reduction or termination of the treatment, within 24 hours. (2155) (3) For prior authorization requests other than as specified in subparagraph (i), within 15 days. (2155)	the claim for payment. The submission of the notification shall include the submission of all relevant clinical information necessary for the insurer or MA or CHIP managed care plan to evaluate the medical necessity and appropriatenes s of the service. (2155)	evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature. (2154)	licensed psychologist or licensed dentist, in the same or similar specialty that typically manages or consults on the health care service. (2161) (b) Qualifications of clinical reviewer.—A clinical reviewer assigned by an IRO to conduct external review must be a physician or other appropriate health care provider who meets the following minimum qualifications: (1) Has expertise in the treatment of the covered person's or enrollee's medical condition that is the subject of the external review. (2) Is knowledgeable about the recommended health care service through recent or current actual clinical experience treating patients with the same or		information for the insurer or its utilization review entity, or MA or CHIP managed care plan or its utilization review entity, shall be available on the insurer's or MA or CHIP managed care plan's publicly accessible Internet website and provider portal. (2155) (a) An MA or CHIP managed care plan shall establish and maintain an external grievance process, including an expedited external grievance process, by which an enrollee, an enrollee's authorized representative or a health care provider with the written consent of the enrollee or the enrollee's authorized representative may appeal the denial of a grievance

					similar medical condition of the covered person or enrollee. (2164.10)		following completion of the internal grievance process. The external grievance process shall be conducted by n review organization not directly affiliated with the MA or CHIP managed care plan. (2162)
PR	PR St T. 26 § 9005					(f) No group or individual health plan that includes	

						emergency service coverage shall require prior authorization for such services, whether the healthcare provider is a participating provider or not. (§ 9005) (h) A health insurance organization or issuer shall not require prior authorization or referral to obtain obstetrical and gynecological care provided by participating providers who specialize in obstetrics and gynecology. (§ 9005)	

RI	27-18.9 et seq.; 42-14.5-3	(3) During the appeal, a review agent may utilize a reconsideration process in assessing an adverse benefit determination. If utilized, the review agent shall develop a reasonable reconsideration and appeal process, in accordance with this section. For non-administrative, adverse benefit determinations, the period for the reconsideration may not exceed fifteen (15) days from the date the request for reconsideration or appeal is received. (8) The review agent shall also provide for an expedited appeal process for urgent and emergent situations taking into consideration medical exigencies. Notwithstanding any other provision	(b)(3) A utilization review agent shall not retrospectively deny authorization for health care services provided to a covered person when an authorization has been obtained for that service from the review agent unless the approval was based upon inaccurate information material to the review or the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval granted by the review agent. (27-18.9-5)	(b)(1) All initial, prospective, and concurrent non-administrative adverse benefit determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering provider. (27-18.9-5)	(b)(1) All initial, prospective, and concurrent non-administrative adverse benefit determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering provider. (27-18.9-5)	The health insurance commissioner shall have the following powers and duties: (d) To establish and provide guidance and assistance to a subcommittee ("the professional-provider-health-plan work group") of the advisory council created pursuant to subsection (c), composed of healthcare providers and Rhode Island licensed health plans. This subcommittee shall include in its annual report and presentation before the house and senate finance committees the following information:	(b)(3) All internal-level appeals of utilization review determinations not to authorize a health-care service that had been ordered by a physician, dentist, or other provider shall be made according to the following: (i) The reconsideration decision of a non-administrative, adverse benefit determination shall not be made until the utilization review agent's professional provider with the same licensure status as typically manages the condition, procedure, treatment, or requested service under discussion has spoken to, or otherwise provided for, an equivalent two-way, direct communication

		of this chapter, each review agent shall complete the adjudication of expedited appeals, including notification of the beneficiary and provider of record of its decision on the appeal, not later than seventy-two (72) hours after receipt of the claimant's request for the appeal of an adverse benefit determination. (27-18.9-7)				(1) A method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients; (2) A standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating healthcare providers; (3) The uniform health plan claim form utilized by participating providers; (42-14.5-3)	with the beneficiary's attending physician, dentist, other professional provider, or other qualified professional provider responsible for treatment of the beneficiary concerning the services under review. (27-18.9-7)

SC	§§ 38-71-144; 44-6-1050					A grant of prior authorization for a drug is specific to the drug, rather than the actual prescription, and extends to all refills allowed pursuant to the original prescription and to subsequent prescriptions for the same drug at the same dosage provided the time allowed by the prior authorization has not expired. process. (44-6-1050)	(B) If a health benefit plan that covers the treatment of stage four advanced, metastatic cancer denies a **prior authorization** request or a claim for a recognized diagnostic imaging service for a covered person's stage four advanced metastatic cancer based upon an adverse medical necessity determination, then the covered person shall have a right to an expedited external review in accordance with Section 38-71-1980. (38-71-144) A Medicaid recipient who has been denied prior authorization for a prescribed drug is entitled to appeal this decision through the department's appeals process. (44-6-1050)

SD	SDCL § 58-17H et seq.	A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of §§ 58-17H-27 to 58-17H-32, inclusive, and §§ 58-17H-40 to 58-17H-48, inclusive. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently. . . . (58-17H-19)	For retrospective review determinations, the health carrier shall make the determination within a reasonable period of time, but in no event later than thirty days after the date of receiving the benefit request. In the case of a certification, the health carrier may notify in writing the covered person and the provider rendering the service. If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination	A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies including the Division of Insurance and the Department of Health. (58-17H-17)	Qualified licensed health care professionals shall administer the utilization review program and oversee review decisions. Any adverse determination shall be evaluated by an appropriately licensed and clinically qualified health care provider. (58-17H-18)		

			to the covered person or, if applicable, the covered person's authorized representative, in accordance with section 57 of this Act. The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative, of the determination pursuant to this section may be extended once by the health carrier for up to fifteen days. . . . (58-17H-30)				

TN	Tenn. Code Sections 56-7-3701-22; (56-61-102)	(2) Utilization review organizations shall perform: (A) A non-urgent prior authorization review within seven (7) calendar days; and (B) An urgent care prior authorization review within seventy-two (72) hours, plus, if applicable, one (1) additional business day. (56-7-3704)		(b) The clinical review criteria for healthcare services or prescription drugs requiring prior authorization must: (1) Be based on nationally recognized, generally accepted standards for national, clinical criteria, except where state law provides its own standard; (2) Not be arbitrary and must be cited by the utilization review organization; (3) Be developed in accordance with the current standards of a national medical accreditation entity; (4) Ensure quality of care and access to needed healthcare services; (5) Be evidence-based; (6) Be sufficiently flexible to allow deviations from norms when justified on a	(b) An adverse determination regarding a request for prior authorization for a healthcare service must be made by a licensed physician or a healthcare professional with the same or a similar specialty as the healthcare professional requesting the prior authorization. (56-7-3703) (a)(1) For prior authorization adverse determination appeals submitted electronically, a utilization review organization shall ensure that such appeals are reviewed or made by a licensed physician or healthcare professional with the same or a similar specialty as the healthcare professional who requested the initial	A health carrier or utilization review organization shall, at least annually, review its prior authorization requirements and consider removal of prior authorization where a prescription or medical service check is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications. (56-7-3718)	(b)(1) Utilization review organizations shall review all prior authorization adverse determination appeals that are not submitted electronically in accordance with standards set by the National Committee on Quality Assurance. (2) For purposes of this part, prior authorization appeals submitted via facsimile are not submitted electronically. (56-7-3704) (a) A prior authorization request under this section that has not been submitted as an urgent care request by the healthcare provider is deemed approved within seven (7) calendar days, or after the date and time of submission

				case-by-case basis; and (7) Be evaluated and updated in accordance with § 56-7-3618. (56-7-3707)	prior authorization. The reviewing healthcare professional shall: (A) Possess a current and valid non-restricted license to practice in this state or another state or territory of the United States; (B) Be knowledgeable of, and have experience providing, the healthcare services under appeal. (56-7-3704)		if the health carrier or utilization review organization, or its designee: (3) Except for a prior authorization for a prescription drug, fails to notify the healthcare provider that prior authorization is being questioned for medical necessity. (d) If notice is provided pursuant to subdivision (a)(3), then the notice must include the following: (1) A direct phone number to the utilization review organization; (2) Hours of business operation of the utilization review organization's physician with decision-making authority to review the prior authorization; and (3) A statement that

							there is an opportunity to discuss the medical necessity of the healthcare service directly with the healthcare professional who will be responsible for approving or denying the prior authorization of the healthcare service under review. (56-7-3705) (h) A healthcare professional must submit a request for a prior authorization at least five (5) calendar days prior to the provision of the service or therapy for non-urgent prior authorizations. (56-7-3705)

TX	Ins. Section 843.3483; Ins. Section 4201.151; Ins. Section 4201.356; Ins. Section 4201.357; 28 TAC Section 19.1730;	In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation. (843.3483)			A utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in this state and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine in this state. (4201.151)	(2) Denial of preauthorization exemption—A determination that a physician or provider does not qualify for a preauthorization exemption based on the issuer conducting an evaluation of preauthorization requests and demonstrating that the physician or provider received full and final approval for fewer than 90% of the preauthorization requests made for a particular health care service during the most recent evaluation period; (4) Evaluation period—The six-month period preceding an	(b) If not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the denial or the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received. (4201.356) (a) The procedures for appealing an

						evaluation. (28 TAC Section 19.1730) (a) A health benefit plan issuer that provides prescription drug benefits may not require an enrollee to receive more than one prior authorization annually of the prescription drug benefit for a prescription drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. (1369.654)	adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. (4201.357)

UT	Utah Code Annotated § 31A-22-650		(2)(c) An insurer may not revoke an authorization for a drug, device, or covered service if: (A) the enrollee is eligible for coverage under the enrollee's insurance policy; and (B) the enrollee's condition or circumstances related to the enrollee's care have not changed; (v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection (2)(c)(i); and (vi) the		(c) Except as provided in Subsection (3)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States. (31A-22-650)		

			authorization was not based on fraudulent or materially incorrect information from the network provider. (31A-22-650)				

VT	18 V.S.A. § 9418b	(4)(A)(i) For urgent prior authorization requests, a health plan shall approve, deny, or inform the insured or health care provider if any information is missing from a prior authorization request from an insured or a prescribing health care provider within 24 hours following receipt. (B) For nonurgent prior authorization requests: (i) A health plan shall approve or deny a completed prior authorization request from an insured or a prescribing health care provider within two business days following receipt. (ii) A health plan shall acknowledge receipt of the prior authorization request within 24 hours following					

		receipt and shall inform the insured or health care provider at that time if any information is missing that is necessary for the health plan to make a determination on the request. (18 V.S.A. 9418b)					
VI	No Provision						

VA	VA Code § 38.2-3407.15 VA Code § 38.2-3407.15:2	(B) 2. Require that the carrier communicate to the prescriber or his designee within 24 hours, including weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation; (B) 4. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied.	6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a			13. Require that no prior authorization be required for at least one drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine. (38.2-3407.15:2)	

		(38.2-3407.15:2)	covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier. (38.2-3407.15)				

WA	Wash. Rev. Code § 48.43.830 ; Wash. Rev. Code § 48.43.537 ; Wash. Rev. Code § 48.165.050 Wash. Admin. Code § 284-43-2050	(1)(a)(i) For electronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of submission of an electronic prior authorization request. (48.43.830) (1)(a)(i) If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request. (48.43.830) (1)(a)(ii) For electronic		(d) The carrier's prior authorization requirements must be described in detail and written in easily understandable language. The carrier shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The	(2)(b) That each health care provider, physician, or contract specialist making review determinations for an independent review organization is qualified. Physicians, other health care providers, and, if applicable, contract specialists must be appropriately licensed, certified, or registered as required in Washington state or in at least one state with standards substantially comparable to Washington state. Reviewers may be drawn from nationally recognized centers of excellence, academic institutions, and recognized leading practice sites. Expert medical reviewers should have substantial, recent clinical	(1)(a) Develop and promote widespread adoption by payors and providers of guidelines to: (i) Ensure payors do not automatically deny claims for services when extenuating circumstances make it impossible for the provider to: (A) Obtain a preauthorization before services are performed; or (B) notify a payor within twenty-four hours of a patient's admission. (48.165.050)	(19) A carrier or its designated or contracted representative must have a prior authorization process that allows specialists the ability to request a prior authorization for a diagnostic or laboratory service based upon a review of medical records in advance of seeing the enrollee. (284-43-2050)

		expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within one calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. (48.43.830) (b)(i) For nonelectronic standard prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary		clinical review criteria must be evaluated and updated, if necessary, at least annually. (48.43.830)	experience dealing with the same or similar health conditions. The organization must have demonstrated expertise and a history of reviewing health care in terms of medical necessity, appropriateness, and the application of other health plan coverage provisions. (48.43.537)		

		information to make a determination. If insufficient information has been provided to the carrier to make a decision, the carrier shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request. (48.43.830) (b)(ii) For nonelectronic expedited prior authorization requests, the carrier shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make					

		a determination. (48.43.830)					

WV	W. Va. Code Ann. § 5-16-7f	(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the Public Employees Insurance Agency shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request: Provided, That the Public Employees Insurance Agency shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the			(h)(i) If a prior authorization is rejected by the Public Employees Insurance Agency and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. (5-16-7f)	(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: Provided, That the cost of the medication does not exceed $5,000 per day and the health care practitioner shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be	(i) If a prior authorization is rejected by the Public Employees Insurance Agency and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The Public Employees Insurance Agency's medical director has the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business

		following: (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or (2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request. (5-16-7f) (e) If the information submitted is considered incomplete, the Public Employees Insurance Agency shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization, request return the prior authorization to the health care				obtained. (5-16-7f) (k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Public Employees Insurance Agency shall not require the health care practitioner to submit a prior authorization for at least the next six months, or longer if the Public Employees Insurance Agency allows: Provided, That at the end of the six-month time frame, or longer	days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission. (5-16-7f) (l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section. (5-16-7f) (n) The Insurance Commissioner may

		practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. (5-16-7f) (h)(i) Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission. (5-16-7f)				if the Public Employees Insurance Agency allows, the exemption shall be reviewed prior to renewal. (5-16-7f)	assess a civil penalty for a violation of this section. (5-16-7f)

WI	Wis. Admin. Code § 632.855	(3) Denial of treatment. (am) A health care plan or a self-insured health plan that receives a request for prior authorization of an experimental procedure that includes all of the required information upon which to make a decision shall, within 5 working days after receiving the request, issue a coverage decision. (632.855)					
WY	W.S. 1977 § 26-55-101 et seq.	(a) Each health insurer or contracted utilization review entity shall make any current prior authorization requirements and restrictions easily accessible on its website to enrollees, health care providers and the general public. Each health insurer or contracted utilization review entity shall directly furnish those	(e) A health insurer or contracted utilization review entity shall only revoke an exemption at the end of a twelve (12) month period if the health insurer or contracted utilization review entity: (i) Makes a determination that the health	After issuing an adverse determination, the health insurer or contracted utilization review entity shall provide the opportunity to the health care provider to discuss the medical necessity of the health care service with the person who has decision making authority and will be responsible for determining authorization of the health care service	(a) Each health insurer or contracted utilization review entity shall ensure that all adverse determinations are made by a physician or other appropriate licensed health care provider who has: (i) Sufficient medical knowledge in an applicable practice area or specialty; (ii) Knowledge of the coverage criteria;	No health insurer or contracted utilization review entity shall require prior authorization for the provision of medications for opioid use disorder. (26-55-109) (a) A health insurer or contracted utilization review entity	(a) Each health insurer or contracted utilization review entity shall ensure that all appeals of adverse determinations are reviewed by a physician or other appropriate licensed health care provider who has: (i) Sufficient medical knowledge in an applicable practice area or specialty;

		requirements and restrictions within twenty-four (24) hours after being requested by a health care provider. Requirements and restrictions provided or posted under this subsection shall be described in detail but also in easily understandable language. Content published by a third party and licensed for use by a health insurer or contracted utilization review entity may be made available through the health insurer or contracted utilization review entity's secure password protected website, provided that the access requirements of the website do not unreasonably restrict access to any current prior authorization	care provider would not have met the ninety percent (90%), rounded down to the nearest whole number, authorization criteria based on a **retrospective** review of the claims for the particular service for which the exemption applies; (ii) Provides the health care provider with the information it relied upon in making its determination to revoke the exemption; and (iii) Provides the health care provider a plain language explanation of how to appeal the decision. (26-55-112) (b) This section does not limit	under review. The health insurer or contract utilization review entity shall attempt to schedule the discussion within five (5) business days after the health care provider's request. (26-55-105)	(iii) Unless otherwise required under Wyoming law, a current and unrestricted license to practice within the scope of their profession in a state, territory, commonwealth of the United States or the District of Columbia; (iv) Knowledge of the applicable person's medical history and diagnosis. (25-55-104)	shall not require prior authorization for rehabilitative or habilitative services including, but not limited to, physical therapy services or occupational therapy services for the first twelve (12) visits for each new episode of care. For purposes of this subsection, "new episode of care" means treatment for a new condition or treatment for a recurring condition that an enrollee has not been treated within the previous ninety (90) days. (b) This section does not limit the right of a health insurer	(ii) Knowledge of the coverage criteria; (iii) A current and unrestricted license to practice within the scope of their medical profession in a state, territory, commonwealth of the United States or the District of Columbia; (iv) Not been employed by the health insurer or contracted utilization review entity or been under contract with the health insurer or contracted utilization review entity other than to participate in one (1) or more of the health insurer or contracted utilization review entity's health care provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

		requirements and restrictions. (26-55-103)	the right of a health insurer or contracted utilization review entity to deny a claim when an appropriate prospective or **retrospective** review concludes that the health care services were not medically necessary. (26-55-113)			or contracted utilization review entity to deny a claim when an appropriate prospective or retrospective review concludes that the health care services were not medically necessary. (26-55-113)	(v) Not been directly involved in the initial adverse determination; and (vi) Considered 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 insurer or contracted utilization review entity by the enrollee's health care provider, any relevant records provided to the health insurer or contracted utilization review entity by a health care facility, any pertinent material provided by the enrollee and any medical literature provided to the health insurer or contracted utilization review entity by the health care provider.

							(b) The enrollee's health care provider may request upon the initiation of an appeal that the appeal from an adverse determination be made by a physician or a specialist in the area of medicine under appeal. (26-55-106)

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Prior Authorization Bulletin Activity

Arkansas
Bulletin 12-2023
Bulletin 20-2023
Bulletin 16-2024

Massachusetts
Bulletin 2015-08
Bulletin 2016-08
Bulletin 2020-10
Bulletin 2020-21
Bulletin 2021-15
Bulletin 2022-03
Bulletin 2022-05
Bulletin 2022-06
Bulletin 2022-07
Bulletin 2024-01
MassHealth Bulletins
Bulletin 368
Bulletin 369

New Hampshire
Bulletin #INS 25-001-AB

New Jersey
Bulletin No. 24-17

New Mexico
Bulletin 2023-020
Bulletin 2025-001

Pennsylvania
Notice 2024-11

Washington
Technical Assistance Advisory 2023-04

West Virginia
Bulletin No. 24-03a

Agenda Item #4

Hear a Discussion on the Prior Authorization Issue:

- Provider Perspective—*Heather McComas (American Medical Association [AMA])*
- Consumer and Patient Perspective—*Lucy Culp (The Leukemia & Lymphoma Society [LLS]) and Carl Schmid (HIV+Hepatitis Policy Institute)*
- Insurer Perspective—*Miranda Motter (America's Health Insurance Plans [AHIP]) and Danielle Lloyd (AHIP)*

Prior authorization

Heather McComas
Director, Administrative Simplification Initiatives
American Medical Association

Agenda

-Impact of prior authorization (PA) on stakeholders from physicians' perspective

-Solutions to solve PA problems

-Reforms efforts

-Looking ahead

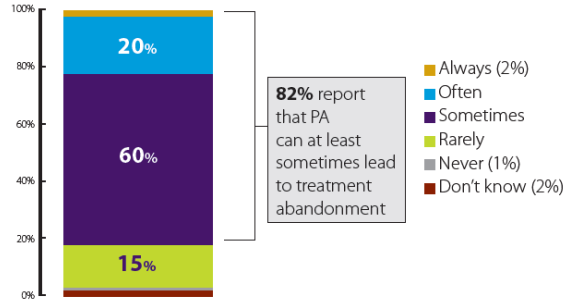
Prior authorization harms patients

29% of physicians report that PA has led to a serious adverse event for a patient in their care.

23% report that PA has led to a patient's hospitalization
18% report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage
8% report that PA has led to a patient's disability, permanent bodily damage, congenital abnormality/birth defect or death

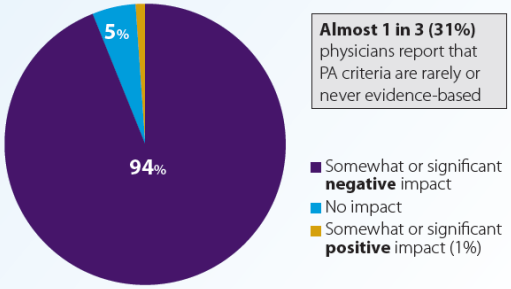
Treatment abandonment due to PA

Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



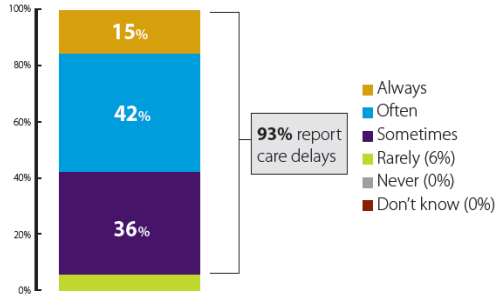
Impact of PA on clinical outcomes

Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?

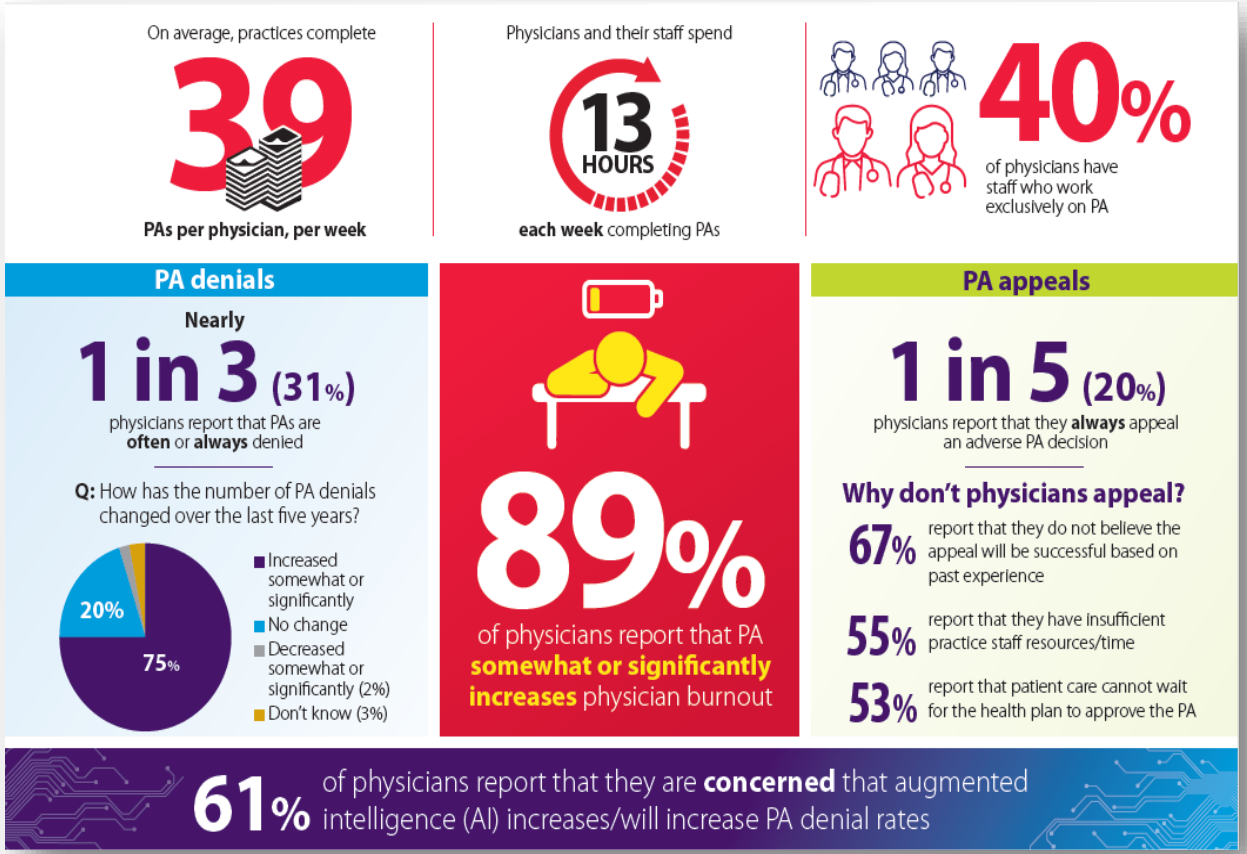


Care delays associated with PA

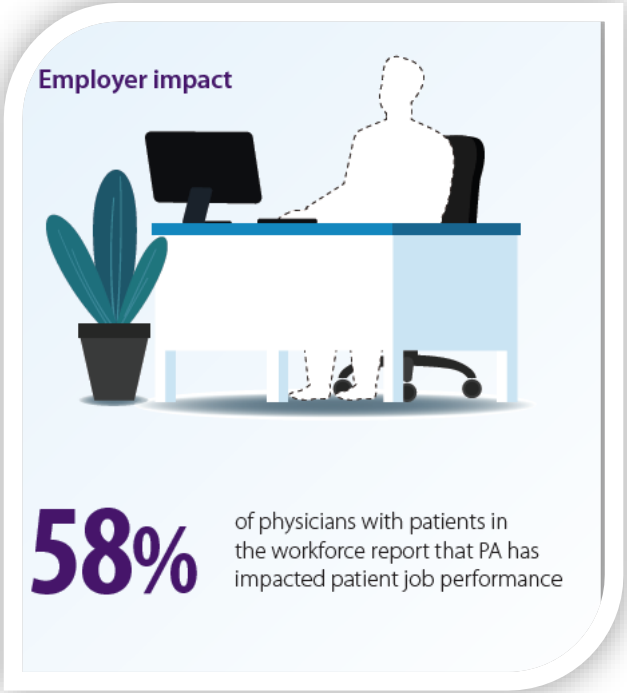
Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



Prior authorization wastes practice resources

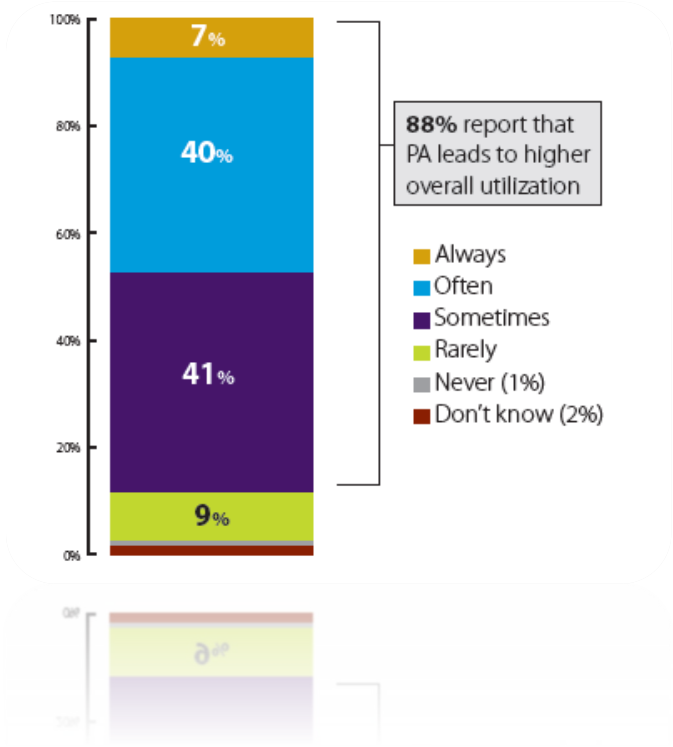


Prior authorization impacts employers



Employers may face reduced productivity if prior authorization causes employees to miss work due to rescheduled appointments or continued illness while waiting for care.

Prior authorization wastes health care resources



77% report ineffective initial treatment (e.g., due to step therapy requirements)

73% report additional office visits

47% report immediate care/ER visits

33% report hospitalizations

Proposed solutions based on identified problems

Faster response times

24 hours for urgent care and 48 for nonurgent.

Use of APIs and ePA w/ standard transactions (must be paired with other solutions since, by itself, ePA could increase use of PA and automation doesn't fix faulty criteria).

Reducing prior authorizations

A prior authorization should be good for the course of treatment.

Eliminate prior auth for care with high approval rates.

Ensuring clinical integrity

Denials made by physician of same specialty, licensed in the state, experience treating condition.

Clinical criteria based on nationally recognized standards of care developed by medical specialty societies.

Data collection and reporting

Rates of approval, denials, appeals, response times, more.

Available to patients, providers, and policymakers.

Summary reports by regulators.

Continuity of care

90+ day grace period when patient is switching plans.

Prevent repeat prior authorizations.

Transparency and more

Decisions are binding (no retroactive denials).

Public clinical criteria and prior authorization requirements.

Reason for adverse determination.

Appeal processes.

Reform efforts

Consensus Statement released in January 2018 by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association

Five reform categories addressed:

- Selective application of PA
- PA program review and volume adjustment
- Transparency and communication regarding PA
- Continuity of patient care
- Automation to improve transparency and efficiency.

Little progress by health plans following the Consensus Statement

American Medical Association
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Family Physicians
American College of Cardiology
American College of Rheumatology
American Hospital Association
American Pharmacists Association
American Society of Clinical Oncology
Arthritis Foundation
Colorado Medical Society
Medical Group Management Association
Medical Society of the State of New York
Minnesota Medical Association

Prior Authorization and Utilization Management Reform Principles

Patient-centered care has emerged as a major common goal across the health care industry. By empowering patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction with provided services and ultimately improve treatment quality and outcomes.

Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care. However, health plans and benefit managers contend that utilization management programs are employed to control costs and ensure appropriate treatment.

Recognizing the investment that the health insurance industry will continue to place in these programs, a multi-stakeholder group representing patients, physicians, hospitals and pharmacists (see organizations listed in left column) has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers and the health care system. **This group strongly urges health plans, benefit managers and any other party conducting utilization management ("utilization review entities"), as well as accreditation organizations, to apply the following principles to utilization management programs for both medical and pharmacy benefits.** We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.

American Hospital Association · AHIP America's Health Insurance Plans · AMA American Medical Association · APhA · BlueCross BlueShield Association · MGMA

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

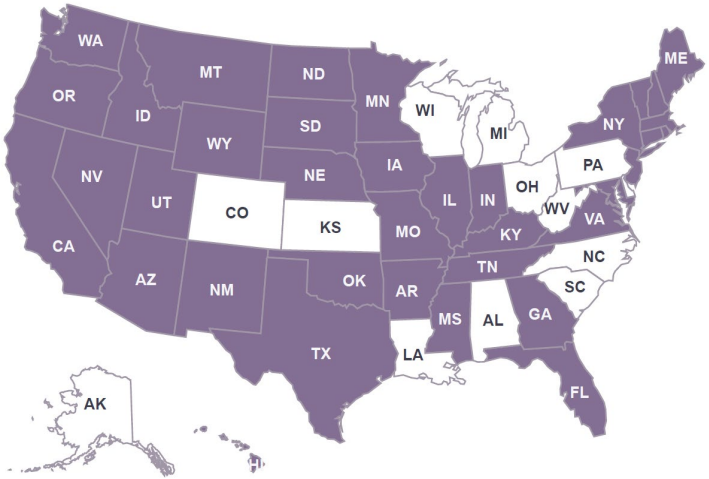
1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

We agree to:

- *Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine*
- *Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers*

State reforms

- Existing state laws
- 100+ bills this year
  - Volume reduction
  - Guardrails on use of AI by plans in the PA process
  - Data collection
  - Continuity of care
  - Automation



Federal reforms

CMS Interoperability and PA Final Rule

Processing timelines: 72 hours for urgent prior authorizations

- AMA advocates for **24 hours** for urgent and **48 hours** for regular PAs

Electronic PA process via application programming interfaces (APIs) that integrate with EHRs

- AMA supports electronic PA process as component of reform
- Concerns with AI programs/lack of human review of denials
- Accessibility for small practices and those in rural or underserved community

Transparency requirements:

- Plans required to post metrics (approval/denial rates; overturns on appeal; average processing time)
- Plans required to provide specific reason for denial, regardless of processing method

Final CY2024 Medicare Advantage Rule

Clinical Validity

- MA plans may only use PA to confirm diagnoses/medical criteria
- MA beneficiaries must have access to the same items and services as they would under traditional Medicare vs. plans using internal proprietary clinical criteria
- MA plans must establish a Utilization Management Committee
- MA plans cannot deny care based on provider type or setting

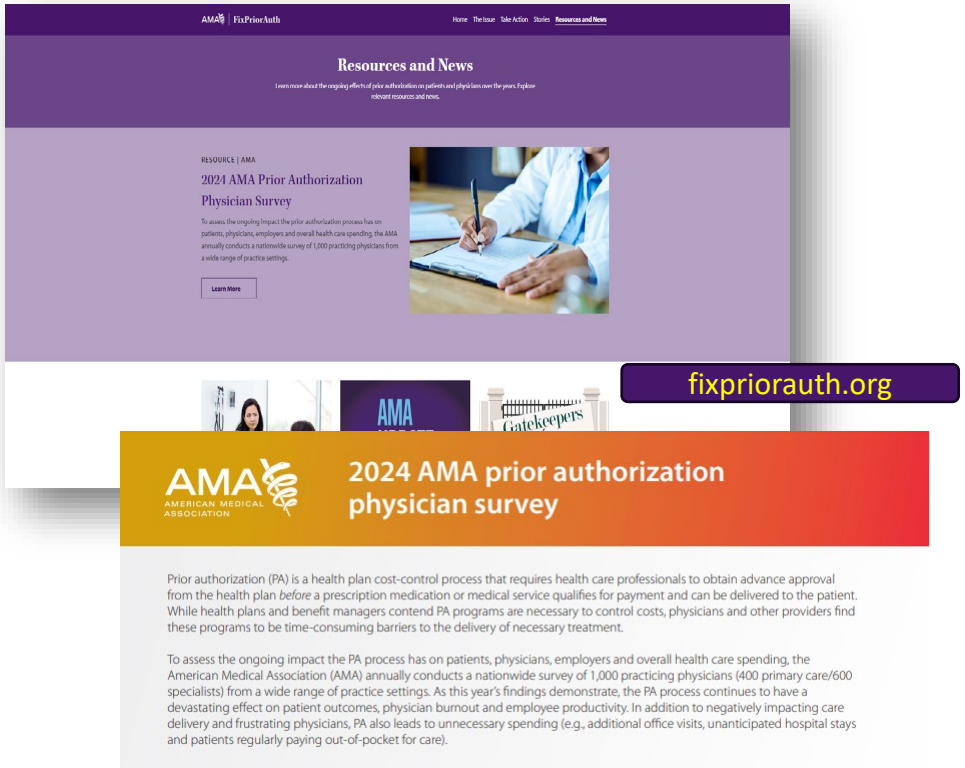
Continuity of Care

- MA plans' PA approvals must remain valid for the duration of the course of treatment
- MA plans must provide beneficiaries with a 90-day transition period where a PA would remain valid for an ongoing course of treatment when beneficiaries change plans
- After PA approval, MA plans cannot retroactively deny coverage

Opportunities for insurance regulators

- State legislation
- Enforcement of existing laws
  - Physician and patient complaints
  - Plan surveys
- Data collection and analysis
- Sharing of effective reforms
- Monitoring and evaluating patient impact of AI

Ready to help



Contact:

Heather McComas

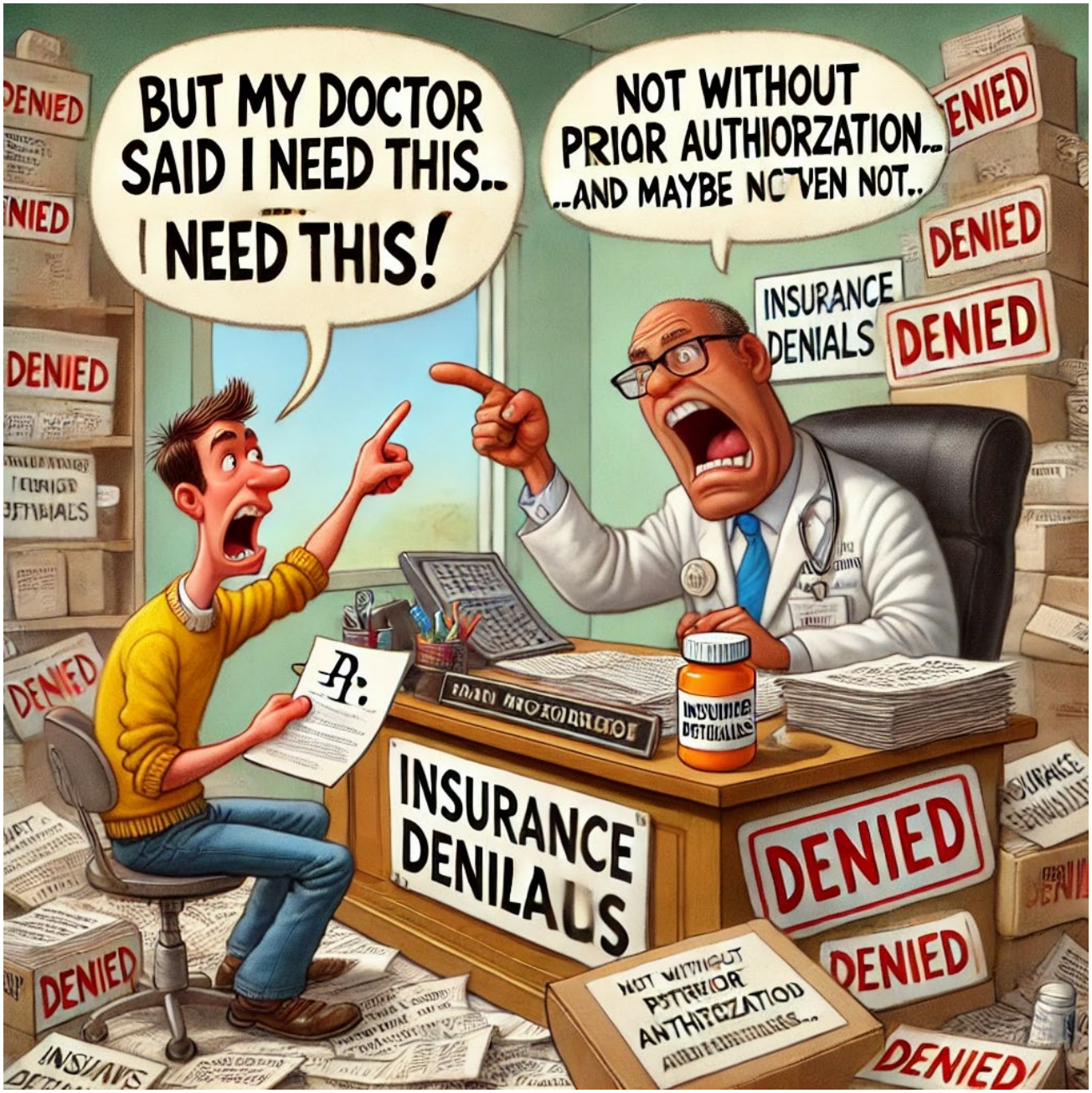
Heather.McComas@ama-assn.org

Consumer Perspectives on Insurer Denials, Prior Authorization & Appeals

CARL SCHMID

HIV + HEPATITIS POLICY INSTITUTE

MARCH 25, 2025


BUT MY DOCTOR SAID I NEED THIS..
I NEED THIS!
NOT WITHOUT PRIOR AUTHIORZATION..
..AND MAYBE NOT EVEN NOT..
INSURANCE DENIALS
DENIED
INSURANCE DENILAUS
DENIED
DENIED
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DENIED


THE WALL STREET JOURNAL.
Health Insurers Deny 850 Million Claims a Year. The Few Who Appeal Often Win.
Patients who contest denials face a daunting process, but many are successful. 'This appeal saved my life.'

KFF

NEWS ALERT

Claims Denials and Appeals in ACA Marketplace Plans in 2023

Justin Lo, Michelle Long, Rayna Wallace, Meghan Salaga, and Kaye Pestaina

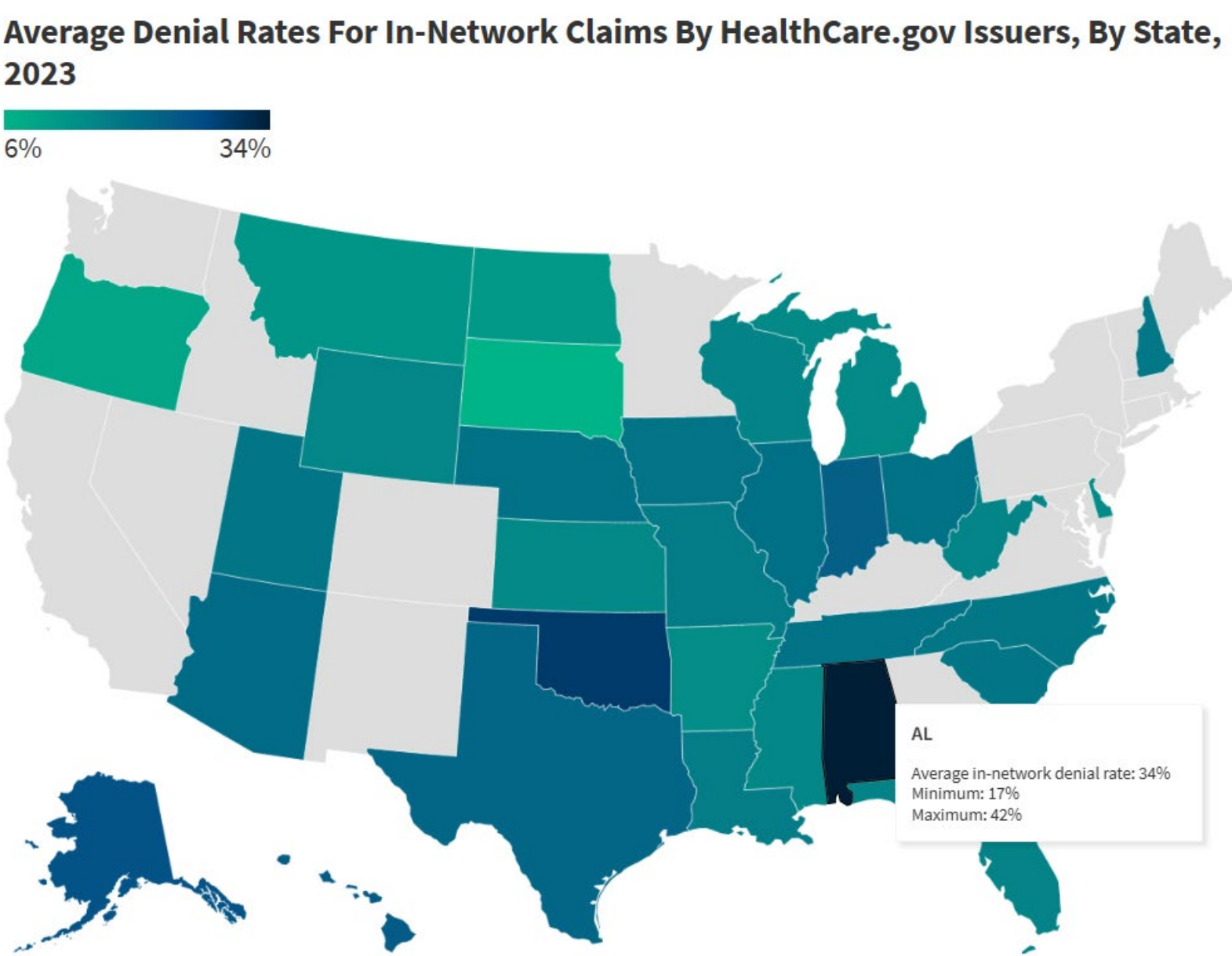
Published: Jan 27, 2025

HealthCare.gov Insurers Denied Nearly 1 in 5 In-Network Claims in 2023, but Information About Reasons is Limited in Public Data

Enrollees Rarely Appeal Claims Denials; When They Do, Insurers Often Uphold the Original Denial

- Consumers rarely appeal denied claims (fewer than 1% of denied claims were appealed) and when they do, insurers usually uphold their original decision (56% of appeals were upheld).

Source: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/



Source: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/

Reasons For In-Network Claims Denials Among HealthCare.gov Plans, 2023

Denial reason	Total	Share
Other reason not listed	24,274,807	34%
Administrative reason	12,591,104	18%
Service excluded	10,988,868	16%
Enrollee benefit limit reached	8,444,754	12%
Lack of referral or prior authorization	6,460,181	9%
Not medically necessary *(excluding behavioral health)*	3,878,165	5%
Member not covered	3,723,250	5%
Not medically necessary *(behavioral health only)*	467,516	1%
Investigational experimental cosmetic procedure	123,173	0%

Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year • Get the data • Download PNG

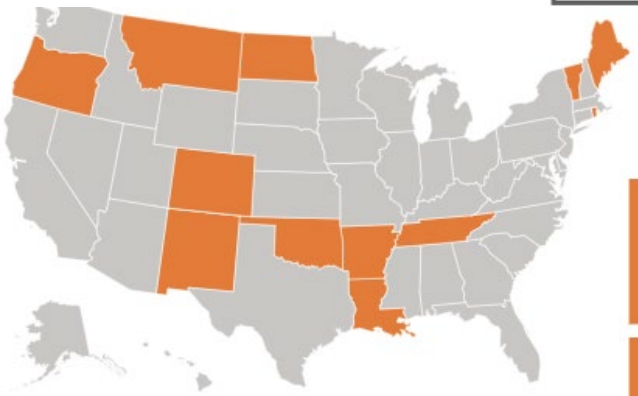
KFF

State PA Laws (2022-24)

Bills
3
States
3
Clear Filters

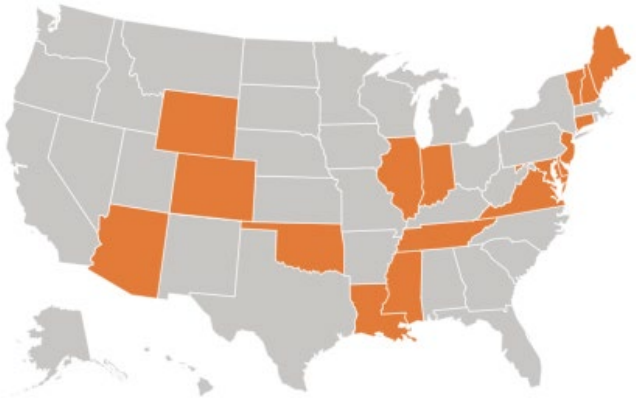
2022

Bills
22
States
12
Clear Filters



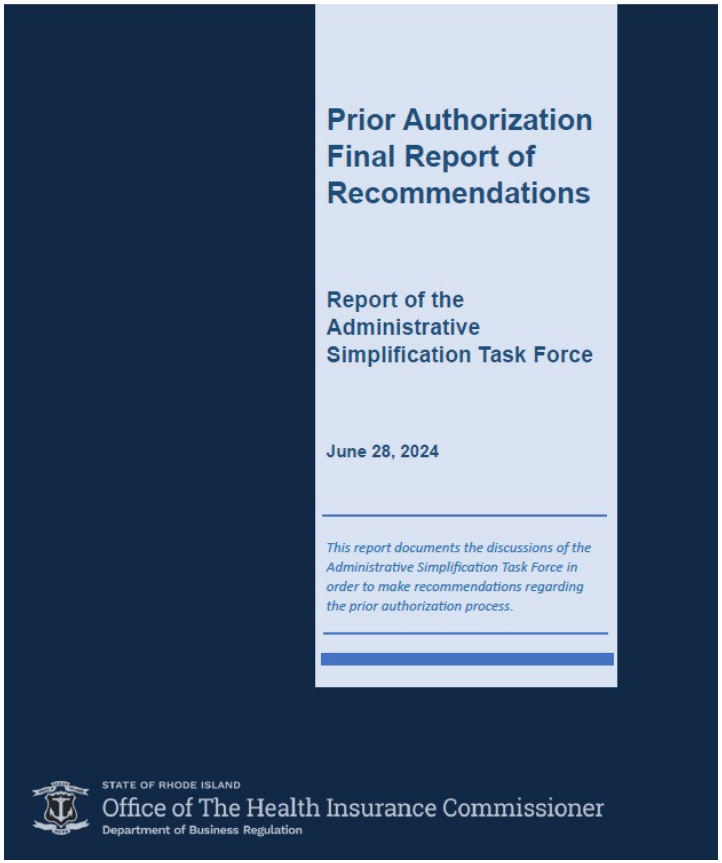
2023

Bills
20
States
17
Clear Filters



2024

States Implementing PA Laws



COLORADO
Department of Regulatory Agencies
Division of Insurance

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE ACCIDENT AND HEALTH

Amended Regulation 4-2-49

CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS AND THE REQUIRED DRUG APPEALS PROCESS

States Considering New Laws

Montana Looks To Regulate Prior Authorization as Patients, Providers Decry Obstacles to Care

By Mike DennisonFebruary 13, 2025

Deny and Delay? California Seeks Penalties for Insurers That Repeatedly Get It Wrong

Christine Mai-Duc:February 18, 2025

Insurers Reducing PA

September 08, 2023 11:35 AM

Michigan Blue Cross to axe 20% of prior authorization requirements

NONA TEPPER

January 30, 2025 11:49 AM

Cigna to spend $150M to improve prior auth, patient advocacy: CEO

NONA TEPPER

March 03, 2025 10:37 AM

UnitedHealthcare to cut 10% of prior authorizations

LAUREN BERRYMAN

Federal Changes that Impact State Efforts

- Prior Authorization and Interoperability final rule
  - Impacts MA, Medicaid, CHIP, and QHPs on the federal marketplace
  - Requirements include: specific reason for denial, shortened response times, public reporting, and automation
  - No changes for prescription drugs, but a proposed rule is anticipated
- 2024 Medicare Advantage final rule
  - Numerous meaningful changes that states can borrow from
  - New limits on use of PA, bans retroactive denials, PA approvals as long as medically necessary, grace period with new plans, expert reviewers, and more!
  - Also includes limits on AI for PA determinations

Suggested Increased Transparency of NAIC MCAS Health Data

National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC), via the Market Conduct Annual Statement (MCAS), collects uniform data annually on claims denials, prior authorization requests, appeals, and more from many insurers in the individual and group markets in nearly every U.S. state. MCAS data are intended to help state insurance regulators monitor the market conduct of insurance companies, and insurers can use this information to identify areas to improve performance. However, full MCAS health insurance data are shared with state regulators only, not the general public or CMS. A limited national summary published by the NAIC shows that the average claims denial rate for both in- and out-of-network claims (excluding pharmacy) in 2023 was about 16%.

MCAS State Ratio Distribution Report for Data Year 2023

Health Ratios - National Level

		2023
Ratio 1	The number of claim denials to the total number of claims received (Excluding Pharmacy)	15.786%
Ratio 2	Percentage of in-network claims (Excluding Pharmacy)	92.964%
Ratio 3	Percentage of out-of-network claims (Excluding Pharmacy)	7.036%
Ratio 4	Percentage of in-network claims paid within 30 days (Excluding Pharmacy)	95.929%
Ratio 5	Percentage of in-network claims denied within 30 days (Excluding Pharmacy)	91.832%
Ratio 6	Percentage of out-of-network claims paid within 30 days (Excluding Pharmacy)	90.284%
Ratio 7	Percentage of out-of-network claims denied within 30 days (Excluding Pharmacy)	85.516%
Ratio 8	Percentage of claims paid (Pharmacy Only)	75.378%
Ratio 9	Insured co payment responsibility to covered lives (Excluding Pharmacy)	$171.04
Ratio 10	Insured coinsurance responsibility to covered lives (Excluding Pharmacy)	$195.42
Ratio 11	Insured deductible responsibility to covered lives (Excluding Pharmacy)	$519.33
Ratio 12	Cost sharing responsibility to covered lives (Pharmacy Only)	$231.17
Ratio 13	Adverse determination grievances per 1,000 member months	1.016
Ratio 14	Adverse determinations overturned to total grievances involving adverse determinations	36.348%
Ratio 15	Adverse determinations upheld to total grievances involving adverse determinations	63.154%
Ratio 16	Grievances not involving adverse determinations per 1,000 member months	0.443
Ratio 17	Customer requested appeals on final adverse determinations to an external review organization (ERO) per 1,000 member months	0.029
Ratio 18	Final adverse determinations upheld upon request for external review to number of requested appeals on final adverse determinations to an external review organization (ERO)	0.592
Ratio 19	Final adverse determinations overturned upon request for external review to number of requested appeals on final adverse determinations to an external review organization (ERO)	0.354

Data on Denied Claims

Qualified Health and Dental Plan Issuers have provided annual data fo

Claims received are defined as the number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital, doctor, or dentist) that is contracted to be part of the network for an issuer.

- A claim means any individual line of service within a bill for services (medical, oral and pharmacy).
- Do not include claims that were pended for additional information and subsequently paid.
- Do not include out-of-network claims.

Claims denied are a received claim that the issuer subsequently denied.

- Include all denials in the total number of claims denied in the calendar year. This includes, but is not limited to:
  - Medical claim pediatric vision and pediatric dental denials;
  - Partial denials;
  - Denials due to ineligibility;
  - Denials due to incorrect submission;
  - Denials for incorrect billing; and
  - Duplicate claims.
- Plan level claim denials are reported beginning Plan Year 2018.

Click the links below to see the information the issuers have provided.

▼ **Aetna CVSHealth:**

Individual Market

2023 Issuer Level Claims

2023 Plan Level Claims

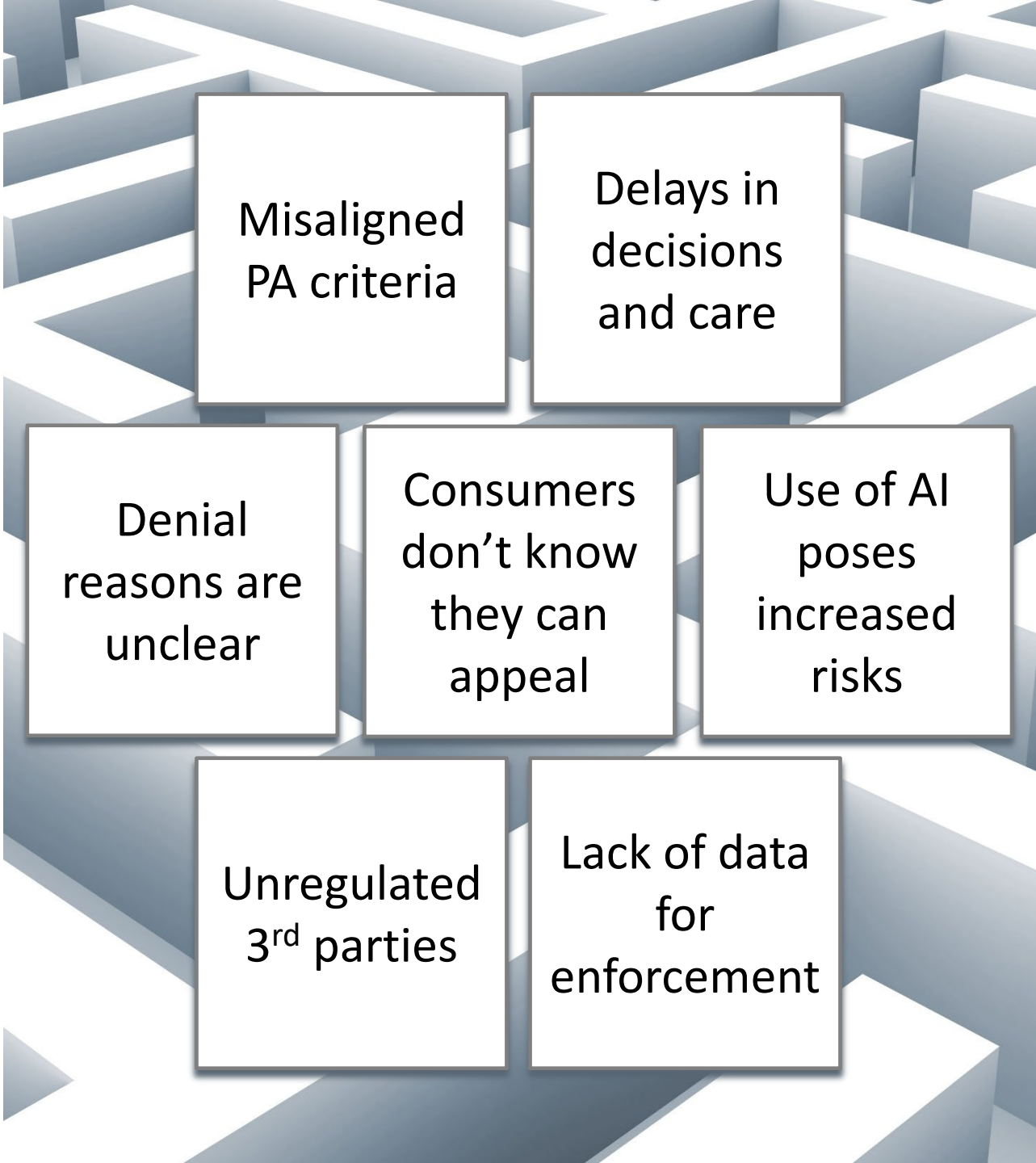
Consumer Recommendations for NAIC Regulatory Framework Task Force:

Prior Authorization White Paper

LUCY CULP

THE LEUKEMIA & LYMPHOMA SOCIETY

Consumers face challenges at many different turns



Explore the implementation and effectiveness of potential policy solutions

PA criteria often misaligned with clinical standards of care

- Transparency in plan documents and on plan websites
- Continuity of care
- Length of approval
- Limitations on PA for certain services
  - Including related protections to avoid new UM being put into place
- Data collection by state agencies
- Reference to clinical standards

Continued: Implementation and effectiveness of potential policy solutions

Delays in decisions and care

- Response time limits
- Interoperability standards

Reason for denial is not clear to consumers or providers

- Reference to clinical standards
- Disclosure of clinical reason for decision to patients and their doctors
- Detailed rationale for additional requests or denials, including admin or medical necessity
- Medical expertise of 3rd party reviewers

Continued: Implementation and effectiveness of potential policy solutions

Consumers don't know they can appeal

- Consumer outreach and education
- Opportunities for 3rd party review of appeals
- "No wrong door" for insurance complaints
- Consumer assistance, navigation programs, and SHIPs

Artificial intelligence and automated decision-making pose risks

- Ensure AI does not perpetuate systemic bias and discrimination against protected classes
- Prohibitions of adverse decisions by AI and other automated decision-making systems
- Meaningful transparency to consumers and regulators
- Monitoring governance and oversight
- Additional work at the NAIC
  - Big Data AI WG health plan survey
  - Model bulletin

Continued: Implementation and effectiveness of potential policy solutions

3rd parties involved in PA lack regulation

- Regulations applied to 3rd parties, including alignment with clinical standards
- Transparency standards
- Audit tools to ensure AI platforms are accurate and do not enshrine bias

Lack of data for enforcement and corrective action

- Robust data collection including service type by plan and category
- Corrective actions for improper denials
- Actuarial assessment framework
- MCAS capabilities and limitations

Thank you!

Carl Schmid

HIV + Hepatitis Policy Institute

cschmid@hivhep.org

Lucy Culp

The Leukemia & Lymphoma Society

lucy.culp@lls.org

Agenda Item #5

Discuss Any Other Matters Brought Before the Task Force
—Commissioner Grace Arnold (MN)