

JAN 23 2025

A BILL FOR AN ACT

RELATING TO PRIOR AUTHORIZATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that prior authorization
2 is a process where a health care provider must get approval from
3 a health insurance plan before providing certain medical
4 services or prescriptions to a patient, ensuring that the
5 treatment is deemed medically necessary and covered by the
6 patient's health insurance plan. Prior authorization helps
7 avoid unsafe or unnecessary treatments, lowers risk of harmful
8 drug interactions, cuts out-of-pocket costs for patients, and
9 confines health insurers' expenses to health care treatments
10 deemed medically necessary. However, prior authorization in the
11 State has become increasingly complex and opaque, causing delays
12 in patient care, increasing administrative burdens, and eroding
13 public trust in the health care system, as the process places
14 cost saving ahead of optimal patient care.

15 The legislature further finds that lawmakers at the state
16 and federal levels have similarly recognized the need for prior
17 authorization reform. In 2023, nine states and Washington, D.C.



1 enacted measures to reform the prior authorization process in
2 their jurisdictions. Further, in 2024, more than ninety bills
3 have been introduced in legislatures across thirty states. New
4 Jersey, Tennessee, and Washington D.C. have recently enacted
5 comprehensive prior authorization reform laws, which will
6 generally increase transparency and improve administrative
7 efficiency around the prior authorization process and align
8 clinical criteria used in making prior authorization
9 determinations to nationally recognized standards.

10 The legislature believes that patient-physician
11 relationship is paramount and should not be subject to third-
12 party intrusion. Furthermore, prior authorization shall not be
13 permitted to hinder patient care or intrude on the practice of
14 medicine. Therefore, prior authorization must be used
15 judiciously, efficiently, and in a manner that prevents cost-
16 shifting onto patients, physicians, and other health care
17 providers.

18 Accordingly, the purpose of this Act is to establish a
19 comprehensive regulatory framework for the prior authorization
20 process in the State.



1 SECTION 2. The Hawaii Revised Statutes is amended by
2 adding a new chapter to be appropriately designated and to read
3 as follows:

4 **"CHAPTER**

5 **ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT**

6 § -1 **Short title.** This chapter shall be known and may
7 be cited as the Ensuring Transparency in Prior Authorization
8 Act.

9 § -2 **Definitions.** As used in this chapter:

10 "Adverse determination" means a decision by a utilization
11 review entity to deny, reduce, or terminate a benefit coverage
12 because the health care services furnished or proposed to be
13 furnished to an enrollee are not medically necessary or are
14 experimental or investigational. "Adverse determination" does
15 not include a decision to deny, reduce, or terminate health care
16 services that are not covered for reasons other than the health
17 care services' medical necessity or experimental or
18 investigational nature.

19 "Authorization" means a determination by a utilization
20 review entity that a health care service has been reviewed and,
21 based on the information provided, satisfies the utilization



1 review entity's requirements for medical necessity and
2 appropriateness and that payment will be made for that health
3 care service.

4 "Clinical criteria" means the written policies, written
5 screening procedures, drug formularies or lists of covered
6 drugs, determination rules, determination abstracts, clinical
7 protocols, practice guidelines, medical protocols, and any other
8 criteria or rationale used by the utilization review entity to
9 determine the necessity and appropriateness of a health service.

10 "Emergency health care services" means health care services
11 that are provided in an emergency facility after the sudden
12 onset of a medical condition that manifests itself by symptoms
13 of sufficient severity, including severe pain, that the absence
14 of immediate medical attention could reasonably be expected by a
15 prudent layperson, who possesses an average knowledge of health
16 and medicine, to result in:

- 17 (1) Placing the patient's health in serious jeopardy;
18 (2) Serious impairment to the patient's bodily function;
19 or
20 (3) Serious dysfunction of any bodily organ or part of the
21 patient.



1 "Enrollee" means an individual eligible to receive health
2 care benefits from a health insurer in the State pursuant to a
3 health plan or other health insurance coverage. "Enrollee"
4 includes an enrollee's legally authorized representative.

5 "Health care facility" has the same meaning as described in
6 section 323D-2.

7 "Health care professional" has the same meaning as defined
8 in section 431:26-101.

9 "Health care provider" means a health care professional or
10 health care facility.

11 "Health care service" means health care procedures,
12 treatments, or services provided by:

13 (1) A facility licensed to provide health care procedures,
14 treatments, or services in the State; or

15 (2) A doctor of medicine, doctor of osteopathy, or other
16 health care professional, licensed in the State, whose
17 scope of practice includes the provision of health
18 care procedures, treatments, or services.

19 "Health care service" includes the provision of pharmaceutical
20 products or services or durable medical equipment.



1 "Medically necessary health care services" means health
2 care services that a prudent physician would provide to a
3 patient for the purpose of preventing, diagnosing, or treating
4 an illness, injury, disease, or its symptoms in a manner that
5 is:

- 6 (1) In accordance with generally accepted standards of
7 medical practice;
- 8 (2) Clinically appropriate in terms of type, frequency,
9 extent, site, and duration; and
- 10 (3) Not primarily for the economic benefit of the health
11 plans and purchasers or for the convenience of the
12 patient, treating physician, or other health care
13 provider.

14 "Medications for opioid use disorder" means medications
15 commonly used in combination with counseling and behavioral
16 therapies, including individual therapy, group counseling,
17 family behavior therapy, motivational incentives, and other
18 modalities, to provide a comprehensive approach to the treatment
19 of opioid use disorder. "Medications for opioid use disorder"
20 approved by the United States Food and Drug Administration
21 include methadone; buprenorphine, whether used alone or in



1 combination with naloxone; and extended-release injectable
2 naltrexone.

3 "NCPDP SCRIPT Standard" means the National Council for
4 Prescription Drug Programs SCRIPT Standard Version 2017071, or
5 the most recent standard adopted by the Department of Health and
6 Human Services. "NCPDP SCRIPT Standard" includes subsequently
7 released versions of the NCPDP SCRIPT Standard.

8 "Prior authorization" means a written or oral determination
9 rendered by a utilization review entity before an enrollee
10 receives a health care service confirming that the health care
11 service is a covered benefit under the applicable plan and that
12 a requirement of medical necessity or other requirements imposed
13 by the utilization review entity as prerequisites for payment
14 for the services have been satisfied.

15 "Urgent health care service" means a health care service
16 which, without an expedited prior authorization could, in the
17 opinion of a physician with knowledge of the enrollee's medical
18 condition:

19 (1) Seriously jeopardize the life or health of the
20 enrollee or the ability of the enrollee to regain
21 maximum function; or



1 (2) Subject the enrollee to severe pain that cannot be
2 adequately managed without the care or treatment that
3 is the subject of the utilization review.

4 "Urgent health care service" includes mental and behavioral
5 health care services.

6 "Utilization review entity" means an individual or entity
7 that review and issues a prior authorization or adverse
8 determination for one or more of the following entities:

- 9 (1) An employer with employees in the State who are
10 covered under a health benefit plan or health
11 insurance policy;
- 12 (2) An insurer that writes health insurance policies;
- 13 (3) A preferred provider organization or health
14 maintenance organization; and
- 15 (4) Any other individual or entity that provides, offers
16 to provide, or administers hospital, outpatient,
17 medical, prescription drug, or other health benefits
18 to a person treated by a health care professional in
19 the State under a policy, plan, or contract.

20 § -3 **Prior authorization requirements and restrictions;**
21 **disclosure and notice required.** (a) A utilization review



1 entity shall make any current prior authorization requirements
2 and restrictions readily accessible on its website to enrollees,
3 health care professionals, and the general public, including the
4 written clinical criteria; provided that requirements shall be
5 described in detail but also in easily understandable language.

6 (b) A utilization review entity that intends to implement
7 a new prior authorization requirement or restriction, or amend
8 an existing requirement or restriction shall:

9 (1) Ensure that the new or amended requirement or
10 restriction is not implemented until the utilization
11 review entity's website has been updated to reflect
12 the new or amended requirement or restriction; and

13 (2) Provide contracted health care providers of enrollees
14 with written notice of the new or amended requirement
15 or amendment no later than sixty days before the
16 implementation of the requirement or restriction.

17 (c) Any entity requiring prior authorization of any health
18 care service shall make statistics on prior authorization
19 approvals and denials available to the public on their website
20 in a readily accessible format; provided that the statistics
21 shall include categories for:



- 1 (1) Physician specialty;
- 2 (2) Medication or diagnostic test or procedure;
- 3 (3) Indication offered;
- 4 (4) Reason for prior authorization denial;
- 5 (5) If a prior authorization was appealed;
- 6 (6) If a prior authorization was approved or denied on
- 7 appeal; and
- 8 (7) The time between the submission and subsequent
- 9 response for a prior authorization request.

10 § -4 **Prior authorization review; adverse determination**
11 **personnel; qualifications; criteria.** (a) A utilization review
12 entity shall ensure that all adverse determinations are made by
13 a physician who:

- 14 (1) Possesses a current and valid non-restricted license
- 15 issued pursuant to chapter 453;
- 16 (2) Is of the same specialty as a physician who typically
- 17 manages the medical condition or disease or provides
- 18 the health care service subject to the review;
- 19 (3) Have experience treating patients with the medical
- 20 condition or disease for which the health care service
- 21 is being requested;



1 Provided that the physician shall make the adverse determination
2 under the clinical direction of one of the utilization review
3 entity's medical directors who is responsible for the provision
4 of health care services provided to enrollees of the State;
5 provided further that the medical director shall be a physician
6 licensed in the State.

7 § -5 **Adverse determination; notice and discussion**

8 **required.** Any utilization review entity questioning the medical
9 necessity of a health care service shall notify the enrollee's
10 physician that medical necessity is being questioned. Before
11 issuing an adverse determination, the enrollee's physician shall
12 have the opportunity to discuss the medical necessity of the
13 health care service on the telephone with the physician who will
14 be responsible for determining authorization of the health care
15 service under review.

16 § -6 **Appeal review personnel; qualifications; criteria.**

17 (a) A utilization review entity shall ensure that all appeals
18 are reviewed by a physician who:

- 19 (1) Possesses a current and valid non-restricted license
20 issued pursuant to chapter 453;



1 (2) Is, and has been, in active practice for at least five
2 consecutive years in the same or similar specialty as
3 a physician who typically manages the medical
4 condition or disease;

5 (3) Is knowledgeable of, and has experience providing, the
6 health care services under appeal;

7 (4) Is not employed by a utilization review entity or be
8 under contract with the utilization review entity
9 other than to participate in one or more of the
10 utilization review entity's health care provider
11 networks or to perform reviews of appeals, and
12 otherwise does not have any financial interest in the
13 outcome of the appeal; and

14 (5) Was not directly involved in making the adverse
15 determination.

16 (b) The physician reviewing the appeal shall consider all
17 know clinical aspects of the health care service under review,
18 including but not limited to a review of all pertinent medical
19 records provided to the utilization review entity by the
20 enrollee's health care provider, any relevant records provided
21 to the utilization review entity by a health care facility, and



1 any medical literature provided to the utilization review entity
2 by the health care provider.

3 § -7 **Prior authorization for non-urgent health care**
4 **services; submission of request; determination time frame;**
5 **automatic approval.** (a) A health care professional shall

6 submit a prior authorization request for a non-urgent health
7 care to the utilization review entity no later than five
8 calendar days before the provision of the health care service.

9 (b) A prior authorization request submitted pursuant to
10 subsection (a) shall be deemed approved forty-eight hours after
11 the submission of the request if the utilization review entity
12 fails to:

13 (1) Approve or deny the request and notify the enrollee or
14 the enrollee's health care provider;

15 (2) Request the health care provider for all additional
16 information needed to render a decision; or

17 (3) Notify the health care provider that prior
18 authorization is being questioned for medical
19 necessity,

20 within the forty-eight-hour period. The utilization review
21 entity shall have an additional twenty-four hours to process the



1 request from the time the health care provider submits the
2 additional information requested pursuant to paragraph (2).

3 (c) Any health care provider who fails to submit the
4 information requested pursuant to subsection (b)(2) within
5 twenty-four hours shall submit a new prior authorization
6 request.

7 (d) For the purposes of this subsection, "information
8 needed to make a decision" includes the results of any face-to-
9 face clinical evaluation or second opinion that may be required.

10 **§ -8 Prior authorization request for urgent health care**
11 **services; determination time frame; automatic approval.** (a) A
12 prior authorization request submitted for an urgent health care
13 service shall be deemed approved twenty-four hours after the
14 submission of the request if the utilization review entity fails
15 to:

16 (1) Approve or deny the request and notify the enrollee or
17 the enrollee's health care provider;

18 (2) Request the health care provider for all additional
19 information needed to render a decision; or



1 (3) Notify the health care provider that prior
2 authorization is being questioned for medical
3 necessity,
4 within the twenty-four-hour period. The utilization review
5 entity shall have an additional twelve hours to process the
6 request from the time the health care provider submits the
7 additional information requested pursuant to paragraph (2).

8 (b) Any health care provider who fails to submit the
9 information requested pursuant to subsection (a)(2) within
10 twelve hours shall submit a new prior authorization request.

11 § -9 **Prior authorization for pre-hospital transportation**
12 **and emergency health care services; prohibited.** (a) No
13 utilization review entity shall require prior authorization for
14 pre-hospital transportation or the provision of emergency health
15 care services.

16 (b) Following an emergency admission of an enrollee into a
17 health care facility or provision of an emergency health care
18 service to an enrollee, the enrollee or health care provider
19 shall be given at least twenty-four hours, excluding holidays
20 and weekends, to notify the utilization review entity of the
21 admission or provision of the health care service.



1 (c) A utilization review entity shall cover emergency
2 health care services necessary to screen and stabilize an
3 enrollee; provided that if a health care provider certifies in
4 writing to a utilization review entity within seventy-two hours
5 of an enrollee's admission that the enrollee's condition
6 required emergency health care services, the emergency health
7 care services administered by the health care provider to the
8 enrollee shall be presumed to have been medically necessary and
9 may be rebutted only if the utilization review entity
10 establishes by clear and convincing evidence that the emergency
11 health care service was not medically necessary.

12 (d) No utilization review entity, when determining the
13 medical necessity or appropriateness of an emergency health care
14 service, shall:

15 (1) Consider whether the emergency health care service was
16 provided by a participating or nonparticipating
17 provider; or

18 (2) Impose greater restrictions on the coverage of
19 emergency health care services provided by a
20 nonparticipating provider than those that apply to the
21 same services provided by a participating provider.



1 (e) If an enrollee receives an emergency health care
2 service that requires immediate post-evaluation or post-
3 stabilization services, a utilization review entity shall make
4 an authorization determination within sixty minutes of receiving
5 a request; provided that if the authorization determination is
6 not made within sixty minutes, the stabilization services shall
7 be deemed approved.

8 § -10 **Prior authorization for medications for opioid use**
9 **disorder; prohibited.** No utilization review entity shall
10 require prior authorization for the provision of medications for
11 opioid use disorder.

12 § -11 **Retrospective denial; health care provider**
13 **payment; exceptions.** (a) A utilization review entity shall not
14 revoke, limit, condition, or restrict a prior authorization if
15 care is provided within forty-five business days from the date
16 the health care provider received the prior authorization.

17 (b) A utilization review entity shall pay a health care
18 provider at the contracted payment rate for a health care
19 service provided by the health care provider per a prior
20 authorization unless:



- 1 (1) The health care provider knowingly and materially
2 misrepresented the health care service in the prior
3 authorization request with the specific intent to
4 deceive and obtain an unlawful payment from a
5 utilization review entity;
- 6 (2) The health care service was no longer a covered
7 benefit on the day it was provided;
- 8 (3) The health care provider was no longer contracted with
9 the patients' health insurance plan on the date the
10 care was provided;
- 11 (4) The health care provider failed to meet the
12 utilization review entity's timely filing
13 requirements;
- 14 (5) The utilization review entity is not liable for the
15 claim; or
- 16 (6) The patient was no longer eligible for health care
17 coverage on the day the health care was provided.

18 § -12 **Length of prior authorization.** A prior
19 authorization shall be valid for a minimum of one year from the
20 date the enrollee or the enrollee's health care provider
21 receives the prior authorization and shall be effective



1 regardless of any changes in dosage for a prescription drug
2 prescribed by the health care provider.

3 **§ -13 Duration of prior authorization for treatment for**
4 **chronic or long-term care conditions.** If a utilization review
5 entity requires a prior authorization for a health care service
6 for the treatment of a chronic or long-term care condition, the
7 prior authorization shall remain valid for the duration of the
8 treatment and the utilization review entity shall not require
9 the enrollee to obtain a new prior authorization again for the
10 health care service.

11 **§ -14 Continuity of care for enrollees; prior**
12 **authorization transfers.** (a) Upon receipt of information
13 documenting a prior authorization from the enrollee or from the
14 enrollee's health care provider, a utilization review entity
15 shall honor a prior authorization granted to an enrollee from a
16 previous utilization review entity for at least the initial
17 ninety days of an enrollee's coverage under a new health plan.

18 (b) During the time period described in subsection (a), a
19 utilization review entity may perform its own review to grant a
20 prior authorization.



1 (c) If there is a change in coverage of, or approval
2 criteria for, a previously authorized health care service, the
3 change in coverage or approval criteria shall not affect an
4 enrollee who received prior authorization before the effective
5 date of the change for the remainder of the enrollee's plan
6 year.

7 (d) A utilization review entity shall continue to honor a
8 prior authorization it has granted to an enrollee when the
9 enrollee changes products under the same health insurance
10 company.

11 § -15 **Prior authorization exemptions for health care**
12 **providers.** (a) A utilization review entity shall not require a
13 health care provider to complete a prior authorization request
14 for a health care service for an enrollee to receive coverage;
15 provided that in the most recent twelve-month period, the
16 utilization review entity has approved or would have approved
17 not less than eighty per cent of the prior authorization
18 requests submitted by the health care provider for that health
19 care service, including any approval granted after an appeal.

20 (b) A utilization review entity may evaluate whether a
21 health care provider continues to qualify for exemptions as



1 described in subsection (a) not more than once every twelve
2 months. Nothing in this subsection shall be construed to
3 require a utilization review entity to evaluate an existing
4 exemption or prevent a utilization review entity from
5 establishing a longer exemption period.

6 (c) A health care provider shall not be required to
7 request for an exemption to qualify for an exemption pursuant to
8 this section.

9 (d) A health care provider who is denied an exemption
10 pursuant to this section may request evidence from the
11 utilization review entity to support the utilization review
12 entity's decision at any time, but not more than once per year
13 per service. A health care provider may appeal a utilization
14 review entity's decision to deny an exemption.

15 (e) A utilization review entity may revoke an exemption
16 only at the end of the twelve-month period described in
17 subsection (b) if the utilization review entity:

18 (1) Determines that the health care provider would not
19 have met the eighty per cent approval criteria based
20 on a retrospective review of the claims for the
21 particular service for which the exemption applies for



1 the previous three months, or for a longer period if
2 needed to reach a minimum of ten claims for review;

3 (2) Provides the health care provider with the information
4 the utilization review entity relied upon in making
5 its determination to revoke the exemption; and

6 (3) Provides the health care provider a plain language
7 explanation of how to appeal the decision.

8 (f) An exemption shall remain in effect until the
9 thirtieth day after the date the utilization review entity
10 notifies the health care provider of its determination to revoke
11 the exemption or, if the health care provider appeals the
12 determination, the fifth day after the revocation is upheld on
13 appeal.

14 (g) A determination to revoke or deny an exemption shall
15 be made by a health care provider licensed in the State of the
16 same or similar specialty as the health care provider being
17 considered for an exemption and have experience in providing the
18 service for which the potential exemption applies.

19 (h) A utilization review entity shall provide a health
20 care provider that receives an exemption a notice that includes:



- 1 (1) A statement that the health care provider qualifies
2 for an exemption from preauthorization requirements;
- 3 (2) A list of services to which the exemptions apply; and
4 (3) A statement of the duration of the exemption.
- 5 (i) A utilization review entity shall not deny or reduce
6 payment for a health care service exempted from a prior
7 authorization requirement under this section, including a health
8 care service performed or supervised by another health care
9 provider when the health care provider who ordered the health
10 care service received a prior authorization exemption, unless
11 the rendering health care provider:
- 12 (1) Knowingly and materially misrepresented the health
13 care service in request for payment submitted to the
14 utilization review entity with the specific intent to
15 deceive and obtain an unlawful payment from the
16 utilization review entity; or
- 17 (2) Failed to substantially perform the health care
18 service.

19 § -16 **Electronic standards for prior authorization.** (a)
20 No later than January 1, 2026, an insurer shall accept and
21 respond to prior authorization requests under the pharmacy



1 benefit plan through a secure electronic transmission using the
2 NCPDP SCRIPT Standard electronic prior authorization
3 transactions; provided that facsimile, propriety payer portals,
4 electronic forms, or any other technology not directly
5 integrated with a physician's electronic health record or
6 electronic prescribing system shall not be considered a secure
7 electronic transmission.

8 (b) For the purposes of this section, "insurer" has the
9 same meaning as defined in section 431:10A-402.

10 § -17 Utilization review entities; annual report to

11 insurance commissioner. (a) No later than March 1 of each
12 year, each utilization review entity shall submit a report to
13 the insurance commissioner on prior authorization requests for
14 the previous calendar year using forms and in a manner
15 prescribed by the insurance commissioner, which shall include:

- 16 (1) A list of all health care services that require prior
17 authorization;
- 18 (2) The number and percentage of prior authorization
19 requests that were approved;
- 20 (3) The number and percentage of prior authorization
21 requests that were denied;



- 1 (4) The number and percentage of prior authorization
2 requests that were initially denied and approved after
3 appeal;
- 4 (5) The number and percentage of prior authorization
5 requests for which the timeframe for review was
6 extended, and the request was approved;
- 7 (6) The average and median time that elapsed between the
8 submission of a non-urgent prior authorization request
9 and a determination by a utilization review entity;
- 10 (7) The average and median time that elapsed between the
11 submission of an urgent prior authorization request
12 and a determination by the utilization review entity;
- 13 (8) The average and median time that elapsed to process an
14 appeal submitted by a health care professional
15 initially denied by the utilization review entity for
16 non-urgent prior authorizations; and
- 17 (9) The average and median time that elapsed to process an
18 appeal submitted by a health care professional
19 initially denied by the utilization review entity for
20 urgent prior authorizations;



1 provided that the information required by paragraphs (2) through
2 (9) shall be individualized for each listed health care service
3 for each health care service listed in paragraph (1).

4 (b) Each utilization review entity shall make the report
5 required pursuant to subsection (a) available to the public
6 through the utilization review entity's website in the format
7 prescribed by the insurance commissioner.

8 § -18 **Insurance commissioner; annual report.** No later
9 than May 1 of each year, the insurance commissioner shall submit
10 a report to the legislature that includes a summary of the
11 reports received pursuant to section -18 that year, including
12 all data received from each utilization review entity, and
13 recommendations for the removal of prior authorization
14 requirements imposed by utilization review entities on health
15 care services that are regularly approved for prior
16 authorization. For the purposes of this section, a health care
17 service with a prior authorization approval rate of eighty per
18 cent or higher shall be considered regularly approved.

19 § -19 **Rules.** No later than January 1, 2026, the
20 insurance commissioner shall adopt rules in accordance with
21 chapter 91 necessary to carry out the purposes of this chapter.



1 § **-20 Non-compliance; automatic approval.** Any failure
2 of an utilization review entity to comply with the provisions of
3 this chapter or any rule adopted thereunder shall result in the
4 health care services subject to the utilization review entity's
5 review being deemed automatically approved.

6 § **-21 Severability.** If any provision of this chapter,
7 or the application thereof to any person or circumstance, is
8 held invalid, the invalidity does not affect other provisions or
9 applications of the chapter that can be given effect without the
10 invalid provision or application, and to this end the provisions
11 of this chapter are severable."

12 SECTION 3. This Act shall take effect upon its approval.

13

INTRODUCED BY: _____

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S.B. NO. 1519

Report Title:

Insurance Commissioner; Ensuring Transparency in Prior Authorization Act; Prior Authorization; Utilization Review Entity; Adverse Determination; Health Care Services; Reports

Description:

Establishes a comprehensive regulatory framework for prior authorization process in the State, including disclosure and notice requirements for utilization review entities regarding their prior authorization requirements and restrictions; qualifications and criteria for prior authorization review and appeals personnel; prior authorization process for non-urgent and urgent health care services, including the time frame by which utilization review entities must render a decision; adverse determination and appeal processes; prohibition of prior authorization for emergency health care services and medication for opioid use disorder; payments to health care providers; length and duration of prior authorizations; and exemptions for certain health care providers. Requires health insurers to utilize NCPDP SCRIPT Standard electronic prior authorization transactions by 1/1/2026. Requires utilization review entities to submit annual reports to the Insurance Commissioner each year. Requires the Insurance Commissioner to submit annual reports to the Legislature. Requires the Insurance Commissioner to adopt rules by 1/1/2026.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

