HB557

5VL5133-1

By Representative Datcher

RFD: Insurance

First Read: 09-Apr-25

SYNOPSIS:

Under existing law, "utilization review," the process by which health insurers determine whether or not to pay or reimburse for health care services, is regulated under the Alabama Department of Public Health.

This bill would place regulation of utilization review functions under the Department of Insurance.

This bill would require health insurers to annually report the number of coverage requests denied to the Department of Insurance and make their coverage criteria accessible to enrollees and health care providers.

This bill would require coverage determinations to be made and communicated to a health care provider within 72 hours for nonurgent care requests and 24 hours for urgent care requests.

This bill would require that coverage determinations be reviewed by a licensed health care professional.

This bill would also require the Department of Insurance to establish an ombudsman to receive and investigate complaints from enrollees and health care providers concerning coverage decisions.

This bill would further provide enforcement

powers to the Department of Insurance, including the authority to impose civil fines on an insurer who violates this act, and would recognize that an enrollee aggrieved by a utilization review determination may pursue civil damages.

A BILL

TO BE ENTITLED

AN ACT

Relating to health insurance; to amend Sections 27-3A-1, 27-3A-2, 27-3A-3, 27-3A-4, 27-3A-5, and 27-3A-6, Code of Alabama 1975, to further regulate utilization review by health insurers; to place enforcement of utilization review requirements under the Department of Insurance; to provide time limits for determinations of coverage and the resolution of appeals of coverage denials; to require that determinations of coverage be reviewed by a licensed health care professional; to require the the Department of Insurance to establish an ombudsman program to receive complaints from enrollees and health care providers; to provide civil penalties for violations of this act; and to add Section 27-3A-7 to the Code of Alabama 1975, to recognize that an enrollee may have a civil action for damages.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 27-3A-1, 27-3A-2, 27-3A-3, 27-3A-4,

27-3A-5, and 27-3A-6, Code of Alabama 1975, are amended to read as follows:

"§27-3A-1

This chapter may be cited as the "Health Care Service Utilization Review, Accountability, and Transparency Act.""

"§27-3A-2

The purposes of this chapter are to:

(1) Promote the delivery of quality health care in a cost-effective manner in the recognition that Alabamians have a right to timely and equitable access to medically necessary care.;

(2) Assure that utilization review agents adhere to reasonable standards for conducting utilization review.;

(3) Foster greater coordination and cooperation between health care providers and utilization review agents.;

(4) Improve communications and knowledge of benefit plan requirements among all parties concerned before expenses are incurred, and to require transparency and oversight of insurance operations in order to ensure fair treatment of Alabama consumers.;

(5) Ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable laws; and

(6) Hold health insurers accountable for industry practices that deny or delay medically necessary care that results in harm to consumers."

"§27-3A-3

As used in this chapter, the following words and

phrases ~~shall~~ have the following meanings:

(1) ARTIFICIAL INTELLIGENCE. A machine-based system that may include software or physical hardware that performs tasks, based upon data set inputs, which require human-like perception, cognition, planning, learning, communication, or physical action and which is capable of improving performance based upon learned experience without significant human oversight toward influencing real or virtual environments.

(2) COMMISSIONER. The Commissioner of the Alabama Department of Insurance.

(3) COVERAGE DENIAL. A coverage determination by a utilization review agent to deny or refuse to certify a payment or reimbursement for a health care treatment, admission, service, procedure, or medication.

(4) COVERAGE DETERMINATION. A written or oral determination made by a utilization review agent that a treatment, admission, service, procedure, or medication, under the enrollee's clinical circumstances is or is not: (i) a benefit covered under the applicable health benefit plan; (ii) medically necessary; or (iii) in compliance with another requirement in the policies or guidelines imposed by the utilization review agent, and thus satisfies the requirements for payment or reimbursement.

~~(1)~~(5) DEPARTMENT. The Alabama Department of Insurance ~~Public Health~~.

~~(2)~~(6) ENROLLEE. An individual who has contracted for or who participates in coverage under ~~an insurance policy, a health maintenance organization contract, a health service~~

~~corporation contract,~~a health benefit plan ~~an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the eligible dependents of the individual~~.

(7) HEALTH BENEFIT PLAN. a. Any plan, policy, or contract issued, delivered, or renewed in this state by an insurer that provides health coverage that includes payment for hospitalization, physician care, treatment, surgery, therapy, drugs, equipment, and any other medical expense, regardless of whether the plan is for a group or an individual.

b. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies, or coverage issued as supplemental to liability insurance, workers' compensation, or automobile medical payment insurance.

(8) INSURER. Any entity that issues, delivers, or renews a health benefit plan, including a person as defined in Section 27-1-2, a health maintenance organization established under Chapter 21A, or a nonprofit health care services plan established under Article 6, Chapter 20, Title 10A.

(9) POLICIES AND GUIDELINES. Written standards developed or adopted by a utilization review agent, which include parameters and considerations for prior authorization or coverage of treatments, services, procedures, medications, diagnostic services, therapies, final medical policies, and

medical policies in draft form.

~~(3)~~(10) PROVIDER. A health care provider~~ duly~~ licensed or certified by the State of Alabama.

(11) URGENT CARE REQUEST. A request for a coverage determination for treatments, services, procedures, medications, diagnostic services, or therapies for which the time period for making a nonurgent determination of prior authorization could result in at least one of the following outcomes for the enrollee:

a. Death.

b. Permanent impairment of health.

c. Inability to regain maximum bodily function.

d. Severe pain that cannot be adequately managed.

~~(4)~~(12) UTILIZATION REVIEW. A system for prospective and concurrent review of the medical necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an individual within this state, including a coverage determination on a request for prior authorization or otherwise. The term does not include ~~elective~~ requests for clarification of coverage.

~~(5)~~(13) UTILIZATION REVIEW AGENT. Any ~~person or~~ entity~~,~~ ~~including the State of Alabama, performing a utilization review~~that makes coverage determinations and performs other utilization review functions for an insurer in the administration of a health benefit plan, except the following:

a. An agency of the federal government.

b. An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to

the federal government.

c. The internal quality assurance program of a hospital.

d. An employee of a utilization review agent.

~~e. Health maintenance organizations licensed and regulated by the state, but only to the extent of providing a utilization review to their own members.~~

~~f. Any entity that has a current accreditation from the Utilization Review Accreditation Commission (URAC). However, entities with current URAC accreditation shall file a URAC certification with the department annually.~~

~~g.~~e. An entity performing utilization reviews or bill audits, or both, exclusively for workers' compensation claims pursuant to Section 25-5-312. If an entity also performs services for claims other than workers' compensation, it shall be considered a private review agent subject to this chapter for those claims.

~~h.~~f. An entity performing utilization reviews or bill audits, or both, exclusively for the Medicaid Agency.

~~i.~~g. A person performing utilization reviews or bill audits, or both, exclusively for their company's health plan, independent of a utilization review ~~company~~agent.

~~j.~~h. An insurance company licensed by the State of Alabama performing utilization reviews or bill audits, or both, exclusively for their company's health plan, independent of a utilization review ~~company~~agent.

~~k.~~i. The Peer Review Committee of the Alabama State Chiropractic Association."

"§27-3A-4

(a) Utilization review agents shall adhere to the minimum standards set forth in Section 27-3A-5.

(b) ~~On or after July 1, 1994, a~~ A utilization review agent shall not conduct a utilization review in this state unless the agent has certified to the department in writing that the agent is in compliance with Section 27-3A-5. Certification shall be made annually on or before July 1 of each calendar year. In addition, a utilization review agent shall file the following information:

(1) The name, address, telephone number, and normal business hours of the utilization review agent.

(2) The name and telephone number of ~~a person~~an individual for the department to contact.

(3) A description of the appeal procedures for utilization review determinations.

(c) Any material changes in the information filed in accordance with ~~this section~~subsection (b) shall be filed with the ~~State Health Officer~~commissioner within 30 days of the change.

(d) ~~Unless exempted pursuant to paragraph f. of subdivision (5) of Section 27-3A-3, each~~Each utilization review agent, upon filing the certification under subsection (b), shall pay an annual fee in the amount of one thousand dollars ($1,000) to the department. All fees paid pursuant to this subdivision shall be held by the department as expendable receipts for the purpose of administering this chapter.

(e) No later than March 31 of each year, a utilization

review agent shall file a report with the commissioner which shall include all of the following information for the previous calendar year:

(1) The total number of coverage determinations.

(2) The number of coverage denials, arranged by category of treatment, admission, service, procedure, or medication.

(3) Within each category of coverage denial as required under subdivision (2), the principal reason for the denial, ranked in order according to numerical frequency.

(f) The commissioner shall make available to the public the information filed by the insurer pursuant to subsection (c) by posting the information in an accessible format on the website of the department.

~~(e)~~ (g) The department may adopt rules ~~pursuant to the Administrative Procedure Act necessary~~ to implement this chapter."

"§27-3A-5

~~(a) Except as provided in subsection (b), all~~All utilization review agents shall meet the following minimum standards:

(1) Notification of a coverage determination by the utilization review agent shall be electronically mailed ~~or otherwise communicated~~ to the provider of record or the enrollee or other appropriate individual within ~~two business days~~72 hours of the receipt of ~~the~~a request for coverage determination and the receipt of all information necessary to complete the review.

(2) Notification of a coverage determination by the utilization review agent shall be electronically mailed to the provider of record or the enrollee or other appropriate individual within 24 hours of the receipt of a request for coverage determination for urgent care and the receipt of all information necessary to complete the review.

(3) A request for coverage determination is deemed granted when all information necessary to complete the review is received by the utilization review agent and notification is not provided to the provider of record or the enrollee or other appropriate individual within the applicable time period required for a nonurgent care request under subdivision (1) or a request for urgent care under subdivision (2).

~~(2)~~ (4) Any coverage determination by a utilization review agent as to the necessity or appropriateness of ~~an~~a treatment, admission, service, ~~or~~ procedure, or medication shall be reviewed by a physician or other provider ~~or determined in accordance with standards or~~ for compliance with policies and guidelines ~~approved by a physician~~.

~~(3)~~ (5) Any notification of coverage determination not to certify ~~an~~a treatment, admission, service, ~~or~~ procedure, or medication shall include the principal reason for the determination and the procedures to initiate an appeal of the determination.

~~(4)~~ (6) Utilization review agents shall maintain and make available a written description of the appeal procedure by which the enrollee or the provider of record may seek review of a coverage determination by the utilization review

agent. The appeal procedure shall provide for the following:

a. On appeal, all coverage determinations ~~not to certify an~~to deny a treatment, admission, service, ~~or~~ procedure, or medications as being medically necessary or appropriate shall be made by a physician in the same or a similar general specialty as typically manages the medical condition~~, procedure, or treatment~~ under discussion as mutually deemed appropriate. A chiropractor ~~must~~shall review all cases in which the utilization review organization has concluded that a determination not to certify a chiropractic service or procedure is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee.

b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify ~~admissions, services, and procedures~~a treatment, admission, service, procedure, or medication no later than ~~30~~five business days in the case of a request for nonurgent care, or no later than 24 hours in the case of a request for urgent care, from the date the appeal is filed and the receipt of all information necessary to complete the appeal.

c. ~~When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis. A representative of a hospital or other health care provider or a representative of the enrollee or covered patient may assist~~

~~in an appeal. Utilization review agents shall complete the adjudication on an expedited basis. Utilization review agents shall complete the adjudication of expedited appeals within 48 hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal. Expedited appeals that do not resolve a difference of opinion may be resubmitted through the standard appeal process~~A determination to deny coverage of a treatment, admission, service, procedure, or medication is deemed reversed, with coverage granted, when a utilization review agent receives all information necessary to complete the appeal but does not complete the adjudication within the time period that applies to a request for nonurgent care or a request for urgent care as required in paragraph b.

(7) Utilization review agents shall maintain an electronic portal to communicate with providers and to receive and respond to coverage determination or prior authorization requests.

~~(5)~~(8) Utilization review agents shall make staff available by toll-free telephone at least ~~40~~55 hours per week ~~during~~that include normal business hours.

~~(6)~~(9) Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to ~~these~~all calls or electronic mail within two ~~working~~business days.

~~(7)~~(10) Utilization review agents shall comply with all applicable laws to protect the confidentiality of individual

medical records, including the federal Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d et seq.

~~(8)~~ (11) Physicians~~, chiropractors, or psychologists~~and other health care professionals who ~~making~~review utilization review determinations and who would require an occupational license to practice their profession in the State of Alabama shall have current licenses from ~~a~~an applicable state licensing board~~ agency in the United States~~.

~~(9)~~ (12) Utilization review agents shall allow a minimum of 24 hours after an emergency treatment, admission, service, or procedure for an enrollee or representative of the enrollee to notify the utilization review agent and request ~~certification or continuing treatment~~a coverage determination for that condition.

(13) Utilization review agents shall make their policies and guidelines easily accessible to enrollees and providers in electronic format.

(14) Utilization review agents shall make coverage determinations that are consistent with the provisions of the health benefit contract, and policies and guidelines that may apply to an enrollee's clinical condition.

(15) A utilization review agent shall ensure that all coverage determinations are reviewed by a physician or other health care professional who is competent to evaluate and reject, if appropriate, any recommendation or conclusion of artificial intelligence that is in conflict with independent professional judgment as informed by an enrollee's unique

clinical condition, the recommendation of the provider, and any applicable policies and guidelines.

~~(b) Any utilization review agent that has received accreditation by the utilization review accreditation commission shall be exempt from this section~~."

"§27-3A-6

(a) The commissioner shall establish an ombudsman program to receive and investigate complaints from enrollees or providers aggrieved by a coverage determination by a utilization review agent.

(b) An ombudsman may do any of the following:

(1) Help an aggrieved enrollee or provider use the utilization review agent's internal appeal process for seeking a reversal or modification of a coverage denial.

(2) Help an aggrieved enrollee or provider understand provisions of a health benefit plan or the utilization review agent's policies and guidelines that may be relevant to a claim, or correspondence received from a utilization review agent.

(3) Based on complaints received, investigate any general business pattern or practice by a utilization review agent that indicates that coverage denials are being made contrary to the requirements imposed pursuant to Sections 27-3A-5(13) through (15).

(4) Audit compliance by a utilization review agent with the coverage provisions of a health benefit plan, its policies and guidelines, and the requirements of this chapter, and issue a report with findings.

(5) Refer a utilization review agent to the department for action pursuant to subsection (c).

(c)(1) Whenever the department has reason to believe that a utilization review agent ~~subject to this chapter~~ has been or is engaged in conduct that violates this chapter, the department shall notify the utilization review agent of the alleged violation. The agent shall respond to the notice not later than 30 days after the notice is made.

~~(b)~~(2) Upon receiving a response from the utilization review agent, ~~If~~if the department finds the response to be unsatisfactory or that the utilization review agent has violated this chapter, or that the alleged violation has not been corrected, the ~~department may conduct a contested case hearing on the alleged violation in accordance with the Administrative Procedure Act~~commissioner may hold a hearing as provided in Article 1, Chapter 2.

~~(c)~~(3) If, after the hearing, the department determines that the utilization review agent has engaged in a violation, the department shall reduce the findings to writing and shall issue and cause to be served upon the agent a copy of the findings and an order requiring the agent to cease and desist from engaging in the violation.

~~(d)~~(4) The department may also exercise either or both of the following disciplinary powers:

~~(1)~~a. Impose an administrative fine of not more than one thousand dollars ($1,000) for a violation, or not more than ~~five~~ten thousand dollars ~~($5,000)~~($10,000) for a violation that occurred with such frequency as to indicate a

general business pattern or practice.

~~(2)~~b. Suspend or revoke the certification of a utilization review agent if the agent ~~knew the act was in violation of this chapter and~~ repeated the act with such frequency as to indicate a general business pattern or practice."

Section 2. Section 27-3A-7 is added to the Code of Alabama 1975, to read as follows:

§27-3A-7

Nothing in this chapter shall be construed to prohibit an enrollee from pursuing any available remedies, including civil damages, in an appropriate forum as a consequence of the determination, act, or omission of a utilization review agent, consistent with other state and federal law.

Section 3. This act shall become effective on October 1, 2025.