SB294

TBD3A59-1

By Senators Orr, Melson

RFD: Banking and Insurance

First Read: 03-Apr-25

SYNOPSIS:

Under existing law, some entities that make decisions on health insurance claims are subject to certain requirements, including registration with the Alabama Department of Public Health.

This bill would set additional minimal standards for health insurers and related entities that handle claims for coverage, including time limits for making prior authorization decisions, and appeals from coverage denials.

This bill would require that insurers use physicians or other appropriately-licensed health care professionals to make coverage determinations.

This bill would also require health insurers to confer "gold card" status on physicans and other health care professionals by waiving the requirement for prior authorization for payment when the physician or other health care professional demonstrates a high level of claims that meet the medical necessity requirement.

A BILL

TO BE ENTITLED

AN ACT

Relating to health insurance; to add Chapter 3B to Title 27 of the Code of Alabama 1975, to further regulate the management and review of insurance claims; to provide a time limit for responding to requests for prior authorization for coverage of a health care service; to require that all decisions on a request for prior authorization be made by a physician or other licensed health care professional; and to require insurers to waive the prior authorization requirement for health care professionals who consistently submit claims that meet medical necessity criteria.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Chapter 3B, commencing with Section 27-3B-1, is added to Title 27 of the Code of Alabama 1975, to read as follows:

§27-3B-1

This chapter shall be known and cited as the Alabama Utilization Review Modernization Act.

§27-3B-2

For the purposes of this chapter, the following terms have the following meanings:

(1) ADDITIONAL BUSINESS DAY. The first weekday not designated as a state or federal holiday.

(2) ADVERSE DETERMINATION. A determination by a utilization review organization that a request for coverage of a benefit under a health benefit plan does not meet the insurer's policies or guidelines for medical necessity or appropriateness, including treatment setting, level of care, or effectiveness. The term includes a denial, reduction,

termination, or modification of the benefit requested or payment therefor.

(3) ARTIFICIAL INTELLIGENCE. A machine-based system that may include software or physical hardware that performs tasks, based upon data set inputs, which requires 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.

(4) ENROLLEE. An individual who contracts for, subscribes, or participates as a dependent under a health benefit plan.

(5) HEALTH BENEFIT PLAN. a. Any plan, policy, or contract issued, delivered, or renewed in this state that provides medical benefits that include payment or reimbursement for hospitalization, physician care, treatment, surgery, therapy, drugs, equipment, and other medical expenses, 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.

(6) HEALTH CARE PROFESSIONAL. A physician or other health care provider who is licensed by an occupational licensing board under Title 34.

(7) HEALTH CARE SERVICE. Diagnosing, testing, monitoring, or treating a human disease, disorder, syndrome, or illness that may include, but not be limited to, hospitalization, physician care, treatment, surgery, therapy, drugs, or medical equipment.

(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 of Title 10A.

(9) MEDICAL NECESSITY. The question of whether a health care service is medically necessary.

(10) NETWORK PROVIDERS. Facilities and health care professionals who, pursuant to a contract with the insurer, have agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayments, coinsurance, or deductibles, directly or indirectly, from the insurer.

(11) PRIOR AUTHORIZATION. A written or oral determination made by a utilization review organization that a health care service is a benefit covered under the applicable health benefit plan which, under the enrollee's clinical circumstances, is medically necessary or satisfies another requirement imposed by the insurer or utilization review organization, and thus satisfies the requirements for payment or reimbursement.

(12) URGENT CARE REQUEST. A request for prior authorization of a health care service 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.

(13) UTILIZATION REVIEW ORGANIZATION. The entity that makes determinations of prior authorization, which may be the insurer or other entity that is a designated contractor or agent of the insurer.

§27-3B-3

(a) A prior authorization request that has not been submitted as an urgent care request is deemed approved if, within 72 hours plus, if applicable, one additional business day, after the date and time of submission of the request, the utilization review organization fails to do one of the following:

(1) Approve, deny, or fail in any way to acknowledge the request.

(2) Request from the network provider all additional information needed to make a determination.

(3) Except for a prior authorization request for a prescription drug, fails to notify the network provider that a determination of prior authorization is delayed because the question of medical necessity is difficult to resolve.

(b)(1) If a network provider is requested to provide additional information, whether in the form of additional

documentation or in the circumstances described in subdivision (2), the utilization review organization shall have an additional 72 hours plus, if applicable, one additional business day, after the date and time of submission of the additional information in which to make its decision or the prior authorization request is deemed approved.

(2) A request for additional information under subdivision (1) shall include, in the case of a question of medical necessity which is difficult to resolve, all of the following:

a. A direct phone number to the utilization review organization.

b. Hours of availability of the utilization review organization's physician or other health care professional who has authority to make the prior authorization determination.

c. A statement that there is an opportunity to discuss the medical necessity of the health care service directly with the physician or other health care professional who has authority to make the prior authorization determination.

(c) Failure by the network provider to submit all clinical information, including its response to a request for additional information, within six calendar days after the date of the initial submission of the request shall necessitate the network provider to request a new prior authorization.

(d) A network provider shall submit a request for a prior authorization that is not an urgent care request at least six calendar days before the scheduled health care

service.

§27-3B-4

(a) A prior authorization request that is submitted as an urgent care request is deemed approved if, within 24 hours after the date and time of submission of the request, the utilization review organization fails to do one of the following:

(1) Approve or deny the request.

(2) Request from the network provider all additional information needed to make a determination.

(b)(1) A network provider shall submit additional information requested by the utilization review organization within 24 hours of receiving a request for additional information.

(2) The prior authorization request is deemed approved by the utilization review organization if it fails to grant or deny the request or otherwise respond to the submission of additional information by the network provider within 24 hours after the date and time of submission of the requested additional information.

(c) Failure by the network provider to submit all clinical information in response to a request for additional information by the utilization review organization within 24 hours after the date and time of the request shall necessitate the network provider to request a new prior authorization.

§27-3B-5

A utilization review organization shall ensure that all determinations on requests for prior authorization are made by

a physician or other health care professional who is competent to evaluate and reject, if appropriate, any recommendation or conclusion of artificial intelligence, based upon all relevant factors that include, but are not limited to, the enrollee's clinical circumstances, the information submitted by the network provider, and all applicable criteria, policies, and guidelines.

§27-3B-6

(a) When a utilization review organization issues an adverse determination in response to a request for prior authorization, it shall send a notification of its determination to both the network provider and enrollee, which shall include all of the following information:

(1) The reasons for the adverse determination and, if applicable, relevant evidence-based criteria, including a description of missing or insufficient documentation, or lack of coverage under the health benefit plan.

(2) Instructions on how to appeal the determination.

(3) Additional documentation or other information necessary to support the appeal.

(b) In addition to the requirement of Section 27-3B-5, a utilization review organization shall ensure that all adverse determinations are made by a physician who meets all of the following requirements:

(1) Possesses a current, nonrestricted license to practice medicine issued by an occupational licensure board in any state or territory of the United States.

(2) Is board-eligible for certification or has

equivalent clinical practice experience in the same specialty as the physician or other health care professional who would typically provide the health care service for which prior authorization is requested.

(3) Makes determinations under the supervision of a medical director who is a current, licensed physician in the State of Alabama.

(4) Receives compensation or payment from the utilization review organization which is in no way increased or enhanced by making an adverse determination.

§27-3B-7

(a) A utilization review organization shall make its process for appealing an adverse determination on a request for prior authorization readily accessible on its website to its network providers and enrollees.

(b) When an appeal is received from a network provider or enrollee on an adverse determination on a request for prior authorization, a utilization review organization shall send a notification to both the network provider and enrollee confirming, reversing, or modifying the adverse determination within: (i) 72 hours plus, if applicable, one additional business day, for a nonurgent request; or (ii) 24 hours for an urgent request.

(c) A utilization review organization shall ensure that all appeals from adverse determinations are decided by a physician other than the physician who made the adverse determination and who meets the requirements of Section 27-3B-6(b)(1) through (4).

§27-3B-8

(a) Beginning January 1, 2026, an insurer shall exempt a health care professional who is a network provider from obtaining prior authorization for a health care service covered under a health benefit plan when all of the following requirements are met:

(1) The health care service is otherwise subject to a prior authorization requirement as a precondition to approval for payment or reimbursement.

(2) The health care professional provided the health care service to at least seven different patients during the year 2025.

(3) Prior authorization was approved, based upon the medical necessity criteria used by the utilization review organization, for 90 percent or more of the requests made by the health care professional for the health care service.

(b) The exemption provided in this section shall be effective for the succeeding year upon determination by the utilization review organization.

(c)(1) Notwithstanding subsection (b), an insurer may rescind the exemption at any time if the health care professional knowingly and materially misrepresents the health care service, including a substantial failure to provide the health care service, in a claim made with the specific intent to deceive the insurer and obtain an unlawful payment or reimbursement.

(2) Notwithstanding subsection (b), an insurer may rescind the exemption no less than 90 days after the exemption

takes effect if the insurer or utilization review organization detects an increase in claims for payment or reimbursement for the health care service for which the exemption is granted that is disproportionate or anomalous to the health care professional's historic rate of providing the health care service.

(3) An insurer shall give written notice to a health care professional that the exemption is being rescinded no less than 20 days in advance of the effective date of the rescission.

(d)(1) An insurer may automatically renew an exemption from prior authorization for a health care service for a succeeding year if the health care professional submits fewer than seven claims for payment or reimbursement for the health care service during the current exemption year, or for any other reason in the insurer's discretion.

(2)a. An insurer may retrospectively review the health care professional's provision of the health care service during the exemption year, using a review period of at least nine months, as a condition for renewing the exemption for the succeeding year.

b. Pursuant to a retrospective review, an insurer may decline to renew the exemption on any of the following grounds:

1. The review discloses that less than 90 percent of the claims paid or reimbursed would meet the medical necessity criteria used by the utilization review organization.

2. The review discloses a claim or a pattern that would

be grounds for rescission of the exemption as described in subsection (c).

(3) An insurer shall make efforts to ensure that written notice of a decision granting or declining renewal of an exemption is provided to a health care professional who has a current exemption no later than at least 30 days before the one-year exemption period expires.

(e)(1) When an insurer rescinds or declines to renew an exemption from prior authorization for a health care service, it shall send written notice of its decision to the health care professional, which shall include: (i) the reason for the decision; and (ii) instructions on how to submit a request for reconsideration of the decision.

(2) A health care professional may submit a request for reconsideration of a decision to rescind or decline renewal of an exemption within 20 days of receiving notice of the health insurer's decision.

(3)a. An insurer shall afford a health care professional a reasonable opportunity, including by a meeting or informal hearing conducted in person or electronically, to challenge the grounds for a decision to rescind or decline renewal of an exemption, to include the presentation of any relevant documentation such as clinical records or claims data as may be relevant to the reason for the insurer's decision.

b. Reconsideration of a decision to decline renewal which involves the issue of medical necessity shall be performed on behalf of the insurer by a physician who meets the requirements of Section 27-3B-6(b).

(4) A decision by a health insurer on reconsideration, affirming or denying its rescission or nonrenewal, is final.

(5) All information, including, but not limited to, oral or written communications, clinical records, supporting documentation, up to the reason for rescinding or declining to renew an exemption, or any decision on a request for reconsideration, shall be held in the strictest confidence by both the insurer and the health care professional, subject to any of the following:

a. Reporting by an insurer of the facts of a case described in subdivision (c)(1) to the commissioner, an occupational licensing board, or law enforcement.

b. Disclosure to a third party by mutual, written agreement of the insurer and the health care professional, subject to the federal Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d et seq.

c. Use by the insurer or health care provider as necessary to invoke or enforce any provision under a network provider contract.

(f) A health care professional who has been granted an exemption from prior authorization for a health care service which has been rescinded or not renewed, and who is otherwise a network provider, remains automatically eligible to receive an exemption for a subsequent year for any health care service he or she provides which may qualify for exemption, unless an exemption was rescinded in a case described in subdivision (c)(1).

(g) An exemption from prior authorization under this

section shall not apply to any health care service that is deemed by the health care insurer to be experimental.

§27-3B-9

This chapter is intended to be construed in pari materia with Chapter 3A, the Health Care Service Utilization Review Act providing for the registration and regulation of utilization review agents by the Alabama Department of Public Health. Where a provision of this chapter conflicts with Chapter 3A, the provision of this chapter shall be given effect.

§27-3B-10

The commissioner may adopt any rules necessary to implement and enforce this chapter.

Section 2. This act shall become effective on October 1, 2025.