LB917
2024

LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 917

Introduced by Wayne, 13.

Read first time January 04, 2024

Committee:

A BILL FOR AN ACT relating to insurance; to define terms; to require the establishment of a standard prior authorization process; to require approval and use of prior authorization forms as prescribed; and to provide certain response time requirements for prior authorization requests.

Be it enacted by the people of the State of Nebraska,

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Section 1. (1) For purposes of this section:

(a) Director means the Director of Insurance;

(b) Health benefit plan has the same meaning as in section 44-1303;

(c) Health care professional has the same meaning as in section 44-1303;

(d) Health care provider has the same meaning as in section 44-1303;

(e) Health carrier has the same meaning as in section 44-1303; and

(f) Pharmacy benefit manager has the same meaning as in section 44-4603.

(2) The director shall adopt and promulgate rules and regulations to establish a standard prior authorization process. Such process shall meet all of the following requirements:

(a) Health carriers and pharmacy benefit managers shall allow health care providers to submit a prior authorization request electronically;

(b) Health carriers and pharmacy benefit managers shall provide that approval of a prior authorization request shall be valid for a minimum length of time in accordance with the rules and regulations adopted and promulgated under this subsection. In setting such minimum time periods, the director may consult with health care professionals who seek prior authorization for particular types of drugs and, as the director determines to be appropriate, negotiate standards for such minimum time periods with individual health carriers and pharmacy benefit managers;

(c) Health carriers and pharmacy benefit managers shall make the following available and accessible on their websites:

(i) Prior authorization requirements and restrictions, including a list of drugs that require prior authorization;

(ii) Clinical criteria that are easily understandable to health care providers, including clinical criteria for reauthorization of a previously approved drug after the prior authorization period has expired; and

(iii) Standards for submitting and considering requests, including

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evidence-based guidelines, when possible, for making prior authorization determinations; and

(d) Health carriers shall provide a process for health care providers to appeal a prior authorization determination as provided in the Health Carrier External Review Act. Pharmacy benefit managers shall provide a process for health care providers to appeal a prior authorization determination that is consistent with the process provided in the Health Carrier External Review Act.

(3) In establishing a standard prior authorization process pursuant to subsection (2) of this section, the director shall consider national standards pertaining to electronic prior authorization, such as those developed by the National Council for Prescription Drug Programs.

(4) The director shall adopt and promulgate rules and regulations to establish a process, for use by each health carrier and pharmacy benefit manager that requires prior authorization for prescription drug benefits pursuant to a health benefit plan, to submit a single prior authorization form for approval by the director. Such form shall be submitted by January 1, 2025, and the submitting health carrier or pharmacy benefit manager shall be required to use such form beginning on July 1, 2025. The process shall provide that if a prior authorization form submitted to the director by a health carrier or pharmacy benefit manager is not approved or disapproved within thirty days after its receipt by the director, the form shall be deemed approved.

(5) In order for a prior authorization form to be approved by the director pursuant to subsection (4) of this section, such form shall:

(a) Not exceed two pages in length, except that a form may exceed such length as determined to be appropriate by the director;

(b) Be available in electronic format; and

(c) Be transmissible in electronic format.

(6) Beginning on July 1, 2025, each health carrier and pharmacy benefit manager shall use and accept the prior authorization form that

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was submitted by that health carrier or pharmacy benefit manager and approved for the use of that health carrier or pharmacy benefit manager by the director pursuant to this section. Beginning on July 1, 2025, health care providers shall use and submit the prior authorization form that has been approved for the use of a health carrier or pharmacy benefit manager, when prior authorization is required by a health benefit plan.

(7) The director shall adopt and promulgate rules and regulations to provide requirements, not to exceed seventy-two hours for urgent claims and five calendar days for nonurgent claims, for a health carrier or pharmacy benefit manager to respond to a health care provider's request for prior authorization of prescription drug benefits or to request additional information from a health care provider concerning such a request.