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LEGISLATIVE BILL 77

Approved by the Governor June 4, 2025

Introduced by Bostar, 29.

A BILL FOR AN ACT relating to insurance; to adopt the Ensuring Transparency in Prior Authorization Act; to provide for insurance and medicaid coverage of biomarker testing as prescribed; to provide operative dates; and to provide severability.

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

Section 1. Sections 1 to 13 of this act shall be known and may be cited as the Ensuring Transparency in Prior Authorization Act.

Sec. 2. For purposes of the Ensuring Transparency in Prior Authorization Act, unless the context otherwise requires:

(1) Adverse determination has the same meaning as in section 44-1303;

(2) Clinical peer means a health care provider in the same, or in a similar, specialty that typically manages the medical condition or health care service under review;

(3) Clinical review criteria has the same meaning as in section 44-1303;

(4) Department means the Department of Insurance;

(5) Emergency health care services means health care services medically necessary to screen and stabilize a patient in connection with an emergency medical condition until the health care provider determines such individual is able to travel using nonmedical transportation;

(6) Emergency medical condition has the same meaning as in section 44-1303;

(7) Enrollee means an individual who is enrolled in a health benefit plan, including covered dependents;

(8) General acute hospital has the same meaning as in section 71-412;

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

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

(11) Health care services has the same meaning as in section 44-1303;

(12) Health carrier has the same meaning as in section 44-1303, except that health carrier does not include a managed care agent;

(13) Medically necessary has the same meaning as in section 44-6845;

(14) Notice means communication delivered either electronically or through the United States Postal Service or a common carrier;

(15) Physician means an individual licensed under the Medicine and Surgery Practice Act to practice medicine and surgery or osteopathic medicine and surgery or an individual with an equivalent license from another United States jurisdiction;

(16) Prior authorization means the process by which a health carrier or utilization review agent makes a determination that a requested admission, extension of stay, or health care service has been reviewed and, based on the information provided, satisfies the health carrier's or utilization review agent's requirements for reimbursement under the applicable health benefit plan;

(17) Urgent health care service means a health care service with respect to which the application of the time periods prescribed under the Ensuring Transparency in Prior Authorization Act for making a nonexpedited prior authorization could, in the opinion of a physician with knowledge of the enrollee's medical condition:

(a) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(b) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

(18) Utilization review agent has the same meaning as in section 44-5418.

Sec. 3. (1) A utilization review agent shall make prior authorization requirements and restrictions, including written clinical review criteria, accessible on its website. Such requirements, restrictions, and clinical review criteria shall be accurate and current and shall clearly communicate what information and documentation is needed to decide the prior authorization. Prior authorization requirements shall also be made available on the website in a searchable format no later than July 1, 2027.

(2) If a utilization review agent intends either to implement a new prior authorization requirement or restriction or to amend an existing requirement or restriction, the utilization review agent shall:

(a) Ensure that the new or amended requirement or restriction is not implemented unless the utilization review agent's website has been updated to reflect the new or amended requirement or restriction; and

(b) Provide contracted health care providers with notice of the new or amended requirement or restriction no less than sixty days before the requirement or restriction is implemented.

Sec. 4. (1) A utilization review agent shall ensure that all adverse determinations for prior authorization are made by a physician, except that if the requesting health care provider is not a physician, the adverse

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determination may be made by a clinical peer of the requesting health care provider. Such physician or clinical peer shall:

(a) Possess a current and valid nonrestricted license in a United States jurisdiction;

(b) Have the appropriate training, knowledge, or expertise to apply appropriate clinical guidelines to the health care service being requested; and

(c) Make the adverse determination under the clinical direction of one of the utilization review agent's medical directors who is responsible for the provision of health care services provided to enrollees of Nebraska. All such medical directors must be physicians licensed in a United States jurisdiction.

(2) When an adverse determination for prior authorization is issued or a prior authorization is canceled or voided, the utilization review agent shall provide notice to the requesting health care provider. The notice shall include the reason for denial, citing written clinical review criteria.

(3)(a) If an adverse determination for prior authorization questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, the enrollee's health care provider shall have the opportunity to discuss the health care service with the physician or clinical peer who is responsible for determining authorization of the health care service under review. The enrollee's health care provider may request that such discussion occur within three business days after receiving notice of the adverse determination. No discussion shall be required or allowed for an adverse determination that is due to contract exclusions or benefits that are not covered by the health benefit plan.

(b) Following any discussion under subdivision (3)(a) of this section, the utilization review agent shall notify the requesting health care provider whether the adverse determination decision remains the same. The notice under this subdivision shall be provided (i) within one business day after the discussion under subdivision (3)(a) of this section for an urgent health care service or (ii) within two business days after the discussion under subdivision (3)(a) of this section for a nonurgent health care service.

(c) A discussion under subdivision (3)(a) of this section shall not replace or eliminate the opportunity for any internal grievance or appeal process provided by the utilization review agent.

Sec. 5. A utilization review agent shall ensure that all appeals of an adverse determination for prior authorization are reviewed by a physician. Such physician shall:

(1) Possess a current and valid unrestricted license in a United States jurisdiction;

(2) Be of the same or similar specialty as the ordering physician or have the training and experience to treat the condition, which means that either:

(a) The physician maintains board certification for the same or similar specialty; or

(b) The physician's training and experience (i) includes treating the condition, (ii) includes treating complications that may result from the health care service, and (iii) is sufficient for the physician to determine based on the physician's clinical judgment whether the health care service is medically necessary or clinically appropriate;

(3) Not have been directly involved in making the initial adverse determination;

(4) Not have any financial interest in the outcome of the appeal; and

(5) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of those medical records which are pertinent and relevant to the active condition provided to the utilization review agent by the enrollee's health care provider, or a health care facility, and any pertinent medical literature provided to the utilization review agent by the health care provider.

Sec. 6. (1)(a) On or before November 1, 2025, the department shall approve a single uniform prior authorization request form for prescription drugs, devices, and durable medical equipment and a single uniform prior authorization request form for all other health care services. The uniform prior authorization request forms shall not exceed two printed pages in length. This two-page limit does not apply to information or documentation required by the utilization review agent, as published in accordance with subsection (1) of section 3 of this act, or a health care provider's notes or documentation submitted in support of a prior authorization request.

(b) Beginning January 1, 2026:

(i) All health care providers shall use only the approved uniform prior authorization request forms; and

(ii) Except as provided in subsection (2) of this section, all utilization review agents shall accept and process prior authorization requests submitted using such forms.

(c) This subsection does not prohibit a utilization review agent from using a prior authorization methodology that uses an Internet webpage, an Internet webpage portal, or a similar web-based system if the methodology is consistent with the uniform prior authorization request forms approved by the department pursuant to this subsection.

(2) A utilization review agent may request from the department an exemption from the requirements of subsection (1) of this section if the utilization review agent implements and maintains a prior authorization application programming interface pursuant to 45 C.F.R. 156.223(b) or other electronic prior authorization methodology that automates and standardizes the prior authorization process for patients, health care providers, and health

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carriers. A utilization review agent shall provide notice to health care providers at least ninety days prior to implementing a prior authorization application programming interface or other electronic prior authorization methodology under this subsection.

Sec. 7. (1) Prior to January 1, 2028, if a utilization review agent requires prior authorization of a health care service, the utilization review agent shall make a decision on the prior authorization request and provide notice of its decision to the enrollee and the enrollee's health care provider in accordance with the following timeframes:

(a) For a prior authorization request for urgent health care services, within seventy-two hours after obtaining all necessary information to make a decision; or

(b) For a prior authorization request for nonurgent health care services, within seven days after obtaining all necessary information to make a decision.

(2) Beginning January 1, 2028, if a utilization review agent requires prior authorization of a health care service, the utilization review agent shall make a decision on the prior authorization request and provide notice of its decision to the enrollee and the enrollee's health care provider in accordance with the following timeframes:

(a) For a prior authorization request for urgent health care services, within forty-eight hours after obtaining all necessary information to make a decision; or

(b) For a prior authorization request for nonurgent health care services, within seven days after obtaining all necessary information to make a decision.

(3) Nothing in this section prohibits a health care provider and health carrier from contracting for shorter timeframes for using the prior authorization application programming interface or other electronic prior authorization methodology described in subsection (2) of section 6 of this act or as part of a risk-sharing agreement.

(4) Health care services are deemed authorized if a utilization review agent fails to comply with the deadlines for making a decision as set forth in this section.

(5) In the notice to the health care provider that a prior authorization has been approved, the utilization review agent shall include the duration of the prior authorization or the date by which the prior authorization will expire.

Sec. 8. No utilization review agent shall require prior authorization of:

(1) Emergency confinement or an emergency health care service;

(2) Pre-hospital transportation for the provision of emergency health care services or for transfers between facilities as required by the federal Emergency Medical Treatment and Labor Act; or

(3) Services that have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as required by 45 C.F.R. 147.130.

Sec. 9. (1) A utilization review agent shall not revoke, limit, condition, or restrict an approved prior authorization if care is provided within sixty days from the date the health care provider received the prior authorization approval unless the enrollee was no longer eligible for care on the day care was provided.

(2) A health carrier shall pay a contracted health care provider at the contracted payment rate for a health care service provided by the health care provider per an approved prior authorization request, unless:

(a) The health care provider knowingly and materially misrepresented the health care service or patient's medical history in the prior authorization request with the intent to deceive and obtain an unlawful payment under the health benefit plan;

(b) The health care service was no longer a covered benefit on the day it was provided;

(c) The health care provider was no longer contracted with the patient's health benefit plan on the date the care was provided;

(d) The health care provider failed to meet the utilization review agent's timely filing requirements;

(e) The patient was no longer eligible for health care coverage on the day the care was provided; or

(f) The health care provider failed to obtain prior authorization approval before rendering health care services for which prior authorization was required.

Sec. 10. (1) Except as otherwise provided in this section, prior authorization shall be valid for at least one year from the date the utilization review agent approves the prior authorization request, except for a prescription drug that has a treatment schedule or dosing limitation from the federal Food and Drug Administration of less than one year.

(2)(a) If a prior authorization is required for inpatient care at a general acute hospital, the prior authorization shall remain valid for the length of stay approved by the utilization review agent.

(b) If the health care provider submits a timely request for the continuation of inpatient care, the utilization review agent shall respond to this request prior to the expiration of the current authorization for inpatient care.

(c) If a utilization review agent fails to respond to a timely request for the continuation of inpatient care prior to the termination of the previously

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approved length of stay, then the health carrier shall continue to compensate the health care provider at the contracted rate for inpatient care provided until the utilization review agent issues its determination on the prior authorization request.

(d) Nothing in this subsection shall be interpreted to prohibit a health care provider or enrollee from appealing an adverse determination as allowed under state law. If an adverse determination is overturned on appeal, and no other legal action related to the claim is pending, then the health carrier shall reimburse the health care provider at the contracted rate for inpatient care provided to the enrollee.

(3) This section does not require a health benefit plan to cover care, treatment, or services for a health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Sec. 11. (1) On receipt of information documenting an approved prior authorization from the enrollee or from the enrollee's health care provider, a utilization review agent shall honor the approved prior authorization granted to an enrollee from a previous utilization review agent for at least the initial sixty days of an enrollee's coverage under a new health benefit plan. During such time period, a utilization review agent may perform its own review to grant a prior authorization.

(2) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria does not affect a prior authorization request approved before the effective date of the change.

(3) A utilization review agent shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes health insurance products under the same health insurance company without any action required by the health care provider.

Sec. 12. (1) An artificial intelligence-based algorithm shall not be the sole basis of a utilization review agent's decision to deny, delay, or modify health care services based, in whole or in part, on medical necessity.

(2) A utilization review agent shall disclose to the department, to each health care provider in its network, to each enrollee, and on its public website if artificial intelligence-based algorithms are used or will be used in the utilization review process.

(3) The department may, at any time, audit a utilization review agent's automated utilization management system. The department may contract with a third-party entity to perform an audit pursuant to this section.

Sec. 13. A utilization review agent shall not:

(1) Be compensated based on its volume of denials; or

(2) Base any incentive or penalty for a medical reviewer of such agent based on the volume of denials such reviewer issues or upholds.

Sec. 14. For purposes of sections 14 to 16 of this act:

(1) Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include, but are not limited to, gene mutations, characteristics of genes, or protein expression;

(2) Biomarker testing means the analysis of tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing;

(3) Clinical utility means sufficient medical and scientific evidence indicating that the use of a biomarker test will provide meaningful information that affects treatment decisions and guides improvement of net health outcomes including an improved quality of life or longer survival;

(4) Consensus statements means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. These statements are aimed at specific clinical circumstances and based on the best available evidence for the purpose of optimizing the outcomes of clinical care;

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

(6) Nationally recognized clinical practice guidelines means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

Sec. 15. (1) On and after January 1, 2028, and notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage and (b) any self-funded employee benefit plan to the extent not preempted by federal law, shall include coverage for biomarker testing pursuant to the criteria established under subsection (2) of this section.

(2) Biomarker testing shall be covered when:

(a) The test is used for:

(i) The diagnosis, treatment, appropriate management, or ongoing monitoring of cancer, an autoimmune or autoinflammatory disease, Parkinson's

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disease, amyotrophic lateral sclerosis, Alzheimer's disease and related dementias, rheumatoid arthritis, preeclampsia, sickle cell anemia, or a cardiovascular condition;

(ii) An organ or tissue transplant; or

(iii) Pharmacogenomic testing; and

(b) The test provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to:

(i) Labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) Indicated tests for a drug approved by the federal Food and Drug Administration;

(iii) Warnings and precautions on drug labels approved by the federal Food and Drug Administration;

(iv) National coverage determinations by the federal Centers for Medicare and Medicaid Services or local coverage determinations by the medicare administrative contractor; or

(v) Nationally recognized clinical practice guidelines and consensus statements.

(3) Coverage, as specified in subsection (2) of this section, shall be provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(4) The patient and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy. The process shall be made readily accessible on the health carrier's website.

Sec. 16. (1) The medical assistance program shall cover biomarker testing no later than January 1, 2028.

(2) Biomarker testing shall be covered when:

(a) The test is used for:

(i) The diagnosis, treatment, appropriate management, or ongoing monitoring of cancer, an autoimmune or autoinflammatory disease, Parkinson's disease, amyotrophic lateral sclerosis, Alzheimer's disease and related dementias, rheumatoid arthritis, preeclampsia, sickle cell anemia, or a cardiovascular condition;

(ii) An organ or tissue transplant; or

(iii) Pharmacogenomic testing; and

(b) The test provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to:

(i) Labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) Indicated tests for a drug approved by the federal Food and Drug Administration;

(iii) Warnings and precautions on drug labels approved by the federal Food and Drug Administration;

(iv) National coverage determinations by the federal Centers for Medicare and Medicaid Services or local coverage determinations by the medicare administrative contractor; or

(v) Nationally recognized clinical practice guidelines and consensus statements.

(3) Coverage, as specified in subsection (2) of this section, shall be provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(4) Entities contracting with the medical assistance program to deliver services to program recipients shall provide biomarker testing at the same scope, duration, and frequency as the medical assistance program otherwise provides to recipients.

(5) The recipient and participating medical assistance program provider shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy of the medical assistance program. The process shall be made readily accessible on the Department of Health and Human Services' website.

Sec. 17. Sections 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 13 of this act become operative on January 1, 2026. The other sections of this act become operative on their effective date.

Sec. 18. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.