Health Insurance Preauthorization Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: John D. Johnson

House Sponsor: Katy Hall

LONG TITLE

General Description:

This bill amends requirements for health insurance preauthorization.

Highlighted Provisions:

This bill:

- requires an insurer to post certain information regarding preauthorizations and preauthorization requirements on the insurer's website;
- requires an insurer to disclose whether the insurer uses artificial intelligence in the process of reviewing a request for authorization;
- defines a maximum time in which an insurer is required to make an authorization or adverse preauthorization determination;
- provides minimum periods that an authorization must be valid for health care services to treat chronic or long-term care conditions;
- amends requirements for reporting to the Insurance Department related to preauthorization statistics, including information related to prescription drugs;
- requires an individual reviewing an adverse preauthorization determination to use independent medical judgment and not rely solely on recommendations from any other source;
- requires an insurer to provide certain information in a notice regarding an adverse preauthorization determination;
- defines terms; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

31A-22-650, as last amended by Laws of Utah 2025, Chapter 473

63I-1-231, as last amended by Laws of Utah 2025, Chapters 241, 473

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-650** is amended to read:

31A-22-650 . Health care preauthorization requirements -- Notice -- Reporting -- Retroactive denial prohibited.

(1) As used in this section:

(a) "Adverse preauthorization determination" means a determination by an insurer that health care does not meet the preauthorization requirement for the health care.

(b)(i) "Artificial intelligence" means the same as that term is defined in Section 53-25-901.

(ii) "Artificial intelligence" includes generative artificial intelligence.

[~~(b)~~] (c) "Authorization" means a determination by an insurer that for health care with a preauthorization requirement:

(i) the proposed drug, device, or covered service meets all requirements, restrictions, limitations, and clinical criteria for authorization established by the insurer;

(ii) the drug, device, or covered service is covered by the enrollee's insurance policy; and

(iii) the insurer will provide coverage for the drug, device, or covered service subject to the provisions of the insurance policy, including any cost sharing responsibilities of the enrollee.

(d) "Authorization validity period" means how long an authorization is valid as specified by the insurer under Subsection 31A-22-650(7).

(e) "Chronic or long-term care condition" means a condition that lasts at least three months and:

(i) requires ongoing medical attention; or

(ii) limits the activities of daily life.

(f) "Decision" means an authorization or an adverse preauthorization determination.

[~~(c)~~] (g) "Device" means a prescription device as defined in Section 58-17b-102.

[~~(d)~~] (h) "Drug" means the same as that term is defined in Section 58-17b-102.

(i) "Duration of authorized covered service" means the duration of a covered service that an insurer authorizes.

(j) "Generative artificial intelligence" means the same as that term is defined in Section 53-25-901.

(k) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

[~~(e)~~] (l) "Insurer" means the same as that term is defined in Section 31A-22-634.

[~~(f)~~] (m) "Preauthorization requirement" means a requirement by an insurer that an enrollee obtain authorization for a drug, device, or service covered by the insurance policy, before receiving the drug, device, or service.

(n) "Urgent care services" means health care services with respect to which the application of the time periods for making a non-expedited authorization, which in the opinion of a physician with knowledge of the enrollee's medical condition, and as supported by documentation:

(i) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(ii) could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request for authorization.

(2) In addition to the requirements described in Section 31A-22-613.5, an insurer shall post on the insurer's website in a conspicuous location accessible by the general public:

(a) all preauthorization requirements in detail and in easily understandable language;

(b) statistics of the insurer's authorizations and adverse preauthorization determinations, including categories for:

(i) the number of authorizations and adverse preauthorization determinations;

(ii) the number of decisions appealed;

(iii) the outcomes of appeals; and

(iv) the average time between an appeal submission and the response to the appeal;

(c) adverse preauthorization determinations that are the result of a provider's failure to submit a request for authorization or a request for authorization's failure to meet the insurer's preauthorization requirements; and

(d) a notice that the insurer uses artificial intelligence in the insurer's processes for reviewing an authorization request, if applicable.

(3) An insurer shall disclose to the department, to each health care provider in the insurer's network, and to each enrollee if the insurer uses artificial intelligence in the insurer's processes for reviewing an authorization request.

[~~(2)~~] (4)(a) An insurer may not modify an existing requirement for authorization unless, at least 30 days before the day on which the modification takes effect, the insurer:

(i) posts a notice of the modification on the website described in Subsection 31A-22-613.5(6)(a); [~~and~~]

(ii) if requested by a network provider or the network provider's representative, provides to the network provider by mail or email a written notice of modification to a particular requirement for authorization described in the request from the network provider[~~.~~] ; and

(iii) updates on the insurer's website the information required under Subsection (2)(a) to reflect the modification.

(b) Subsection [~~(2)(a)~~] (4)(a) does not apply if:

(i) complying with Subsection [~~(2)(a)~~] (4)(a) would create a danger to the enrollee's health or safety; or

(ii) the modification is for a newly covered drug or device.

(c) An insurer may not revoke an authorization for a drug, device, or covered service if:

(i) the network provider submits a request for authorization for the drug, device, or covered service to the insurer;

(ii) the insurer grants the authorization requested under Subsection [~~(2)(c)(i)~~] (4)(c)(i);

(iii) the network provider renders the drug, device, or covered service to the enrollee in accordance with the authorization and any terms and conditions of the network provider's contract with the insurer;

(iv) on the day on which the network provider renders the drug, device, or covered service to the enrollee:

(A) the enrollee is eligible for coverage under the enrollee's insurance policy; and

(B) the enrollee's condition or circumstances related to the enrollee's care have not changed;

(v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection [~~(2)(c)(i)~~] (4)(c)(i); and

(vi) the authorization was not based on fraudulent or materially incorrect information from the network provider.

(5)(a) Except as provided in Subsections (5)(b) and (c), an insurer that receives a request for authorization shall make and notify the network provider of a decision no later than seven calendar days after the day on which the insurer receives all necessary information required to make the decision.

(b) If an insurer that receives a request for authorization for urgent care services and receives all information required to make a decision, the insurer shall make and notify the network provider of a decision no later than 72 hours after the insurer receives all necessary information required to make the decision.

(c) If an insurer receives a request for authorization for urgent care services and does not receive all necessary information for the insurer to make a decision, the insurer shall:

(i) notify the network provider as soon as reasonably possible, but no later than one business day after the day on which the insurer receives the claim, what additional information is required to make a decision;

(ii) allow a network provider a reasonable amount of time, but not less than two business days, to provide the additional information described in Subsection (5)(c)(i); and

(iii) notify the network provider of the decision no later than two business days after the day on which the insurer receives the additional information described in Subsection (5)(c)(ii).

[~~(3)~~] (6)(a) An insurer that receives a request for authorization shall treat the request as a pre-service claim as defined in 29 C.F.R. Sec. 2560.503-1 and process the request in accordance with:

(i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an individual or group health insurance policy;

(ii) Subsection 31A-4-116(2); and

(iii) Section 31A-22-629.

(b) If a network provider submits a claim to an insurer that includes an unintentional error that results in a denial of the claim, the insurer shall permit the network provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time.

(c) Except as provided in Subsection [~~(3)(d)~~] (6)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.

(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:

(i) a physician and surgeon; or

(ii) a pharmacist.

(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:

(i)(A) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or

[~~(ii)~~] (B) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination[~~.~~] ;

(ii) except as provided in Subsection (6)(e)(i)(B), exercises independent medical judgment; and

(iii) does not rely solely on recommendations from any other source.

[~~(f)~~] (7)(a) An insurer shall specify how long an authorization is valid and the duration of authorized covered service.

(b) Except as provided in Subsections (7)(c), (d), and (e), for a drug, device, or covered service to treat a chronic or long-term care condition, an authorization validity period may not be less than 12 months.

(c) An authorization validity period for a drug to treat a chronic or long-term care condition may be for a period shorter than 12 months if the authorization is for an experimental drug.

(d) An insurer may modify the authorization validity period for a drug to treat a chronic or long-term care condition if:

(i) the originally authorized drug is not effective in treating the chronic or long-term care condition;

(ii) a more effective drug is available to treat the chronic or long-term care condition;

(iii) a less costly and equally effective drug is available to treat the chronic or long-term care condition; or

(iv) the originally authorized drug ceases to be covered by the enrollee's health benefit plan.

(e) An authorization validity period for an outpatient covered service may not be less than six months.

[~~(4)~~] (8)(a) An insurer that removes a drug from the insurer's formulary shall:

(i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and

(ii) have a process to review and make a [~~decision~~] determination regarding an exemption requested under Subsection [~~(4)(a)(i)~~] (8)(a)(i).

(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.

[~~(5)~~] (9)(a) Each April 1, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.

(b) Before March 1, 2026, and each March 1 thereafter, an insurer shall report to the department the following for the previous calendar year:

(i) a list of services that have preauthorization requirements;

(ii) for pre-service preauthorization requests that were not urgent, the number and percentage of individual service requests that:

(A) were approved;

(B) were denied;

(C) were approved after appeal;

(D) the time frame for review was extended, and the request was approved;

(E) were denied due to incomplete information from the health care provider; and

(F) were received through fax, phone, and electronic portal; [~~and~~]

(iii) for urgent pre-service preauthorization requests, the number and percentage of individual service requests that:

(A) were approved;

(B) were denied;

(C) were denied due to incomplete information from the health care provider; and

(D) were received through fax, phone, and electronic portal[~~.~~] ;

(iv) the average and median time between when the insurer received a request for authorization and a decision; and

(v) the average and median time to process an appeal that a health care provider submitted for an adverse preauthorization determination.

(c) Data provided to the department under Subsections [~~(5)(b)(ii) and (iii)~~] (9)(b)(ii)

through (v) shall be aggregated for all services.

[~~(d) Subsection (5)(b) does not require an insurer to report information regarding prescription drugs.~~]

[~~(e)~~] (d) The department shall compile the information described in Subsection [~~(5)(b)~~] (9)(b) and publish the information on the department's website.

[~~(6)~~] (10) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.

(11) An insurer shall pay a contracted health care provider under the terms of the plan for a service that was authorized unless:

(a) the health care provider:

(i) was no longer contracted with the enrollee's health benefit plan on the date the service was provided;

(ii) failed to meet the insurer's timely filing requirements; or

(iii) bills a code or service that was not included in the request for authorization and would have resulted in an adverse preauthorization determination if it had been included in the request;

(b) the service was no longer a covered benefit on the day the service was provided;

(c) the insurer does not have liability for a claim; or

(d) the enrollee was no longer eligible for health care coverage on the day the service was provided.

[~~(7)~~] (12) For each adverse preauthorization determination made by an insurer, the insurer shall provide to the enrollee and the enrollee's health care provider:

(a) a detailed and specific explanation that explains why the determination was made; [~~and~~]

(b) a notice that includes the following information for each health care billing code included in the requested authorization on the first page of the notice:

(i) the health care billing codes that were approved; and

(ii) the health care billing codes that were denied; and

[~~(b)~~] (c) a notice explaining the determination may be appealed and the process for appealing the determination, including how to begin an expedited appeal process as described in Section 31A-22-629.

[~~(8)~~] (13) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules to implement Subsection [~~(5)(b)~~] (9)(b).

Section 2. Section **63I-1-231** is amended to read:

63I-1-231 . Repeal dates: Title 31A.

(1) Section 31A-2-217, Coordination with other states, is repealed July 1, 2033.

(2) Subsection [~~31A-22-650(5)(b)~~] 31A-22-650(9)(b), regarding the reporting requirement that includes the number of preauthorizations that were approved and denied, is repealed July 1, 2029.

(3) Subsection [~~31A-22-650(8)~~] 31A-22-650(13), regarding the rulemaking for the preauthorization reporting requirement, is repealed July 1, 2029.

(4) Section 31A-22-627.1, Ground ambulance reimbursement, is repealed July 1, 2027.

Section 3. **Effective Date.**

This bill takes effect on January 1, 2027.