State of Wisconsin
2025 - 2026 LEGISLATURE

LRB-1670/P1
JPC:cdc

DOA:.....Lessner, BB0377 - Prior Authorization Transparency

FOR 2025-2027 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

INSURANCE

Prior authorization transparency

This bill imposes several regulations on the use of prior authorization requirements used by health care plans. Under the bill, "prior authorization" is defined to mean the process by which a health care plan or a contracted utilization review organization determines the medical necessity and medical appropriateness of otherwise covered health care services.

The bill requires health care plans to maintain a list of services for which prior authorization is required and publish the list on its website to be accessible by members of the general public without requiring the creation of any of an account or the entry of any credentials or personal information. Further, the bill requires health care plans to make the current prior authorization requirements and restrictions that it uses accessible and conspicuously posted on its website or on the website of a contracted utilization review organization for enrollees and providers.

The bill provides that any clinical review criteria on which a prior authorization requirement or restriction is based shall satisfy certain criteria, including that the criteria are based on nationally recognized, generally accepted standards except where provided by law, that the criteria are developed in accordance with the current standards of a national medical accreditation entity, and that the criteria ensure quality of care and access to needed health care services.

The bill prohibits a health care plan from denying a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date that the service was provided. Further, the bill prohibits health care plans and utilization review organizations contracted with health care plans from deeming supplies or services as incidental and from denying a claim for supplies or services if a provided health care service associated with the supplies or services receives prior authorization or if a provided health care service associated with the supplies or services does not require prior authorization.

Finally, the bill provides that if a health care plan intends to impose a new prior authorization requirement or restriction or intends to amend a prior authorization requirement or restriction, the health care plan must provide all providers contracted with the health care plan advanced written notice of the new

or amended requirement or restriction no less than 60 days before the new or amended requirement or restriction is implemented. No health care plan may implement a new or amended prior authorization requirement or restriction unless the health care plan or a contracted utilization review organization has updated the post on its website to reflect the new or amended prior authorization requirement or restriction.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 628.42 of the statutes is created to read:

628.42 Disclosure and review of prior authorization requirements.

(1) In this section:

(a) "Health care plan" has the meaning given in s. 628.36 (2) (a) 1.

(b) 1. "Prior authorization" means the process by which a health care plan or a contracted utilization review organization determines the medical necessity and medical appropriateness of otherwise covered health care services.

2. "Prior authorization" includes any requirement that an enrollee or provider notify the health care plan or a contracted utilization review organization before, at the time of, or concurrent to providing a health care service.

(b) "Provider" has the meaning given in s. 628.36 (2) (a) 2.

(2) (a) A health care plan shall maintain a complete list of services for which prior authorization is required, including services where prior authorization is performed by an entity under contract with the health care plan.

(b) A health care plan shall publish the list under par. (a) on its website. The list shall be accessible by members of the general public without requiring the creation of any of an account or the entry of any credentials or personal information.

(c) The list under par. (a) is not required to contain any clinical review criteria applicable to the services.

(3) (a) A health care plan shall make any current prior authorization requirements and restrictions along with the clinical review criteria applicable to those requirements or restrictions accessible and conspicuously posted on its website to enrollees and providers. Content published by a 3rd party and licensed for use by a health care plan or a contracted utilization review organization may satisfy this subsection if it is available to access through the website of the health care plan or the contracted utilization review organization as long as the website does not unreasonably restrict access.

(b) The prior authorization requirements and restrictions under par. (a) shall be described in detail, and shall be written in easily understandable, plain language.

(c) The prior authorization requirements and restrictions under par. (a) shall indicate all of the following for each service subject to the prior authorization requirements and restrictions:

1. When the requirement or restriction began for policies issued or delivered in this state, including effective dates and any termination dates.

2. The date that the requirement or restriction was listed on the website of the health care plan or a contracted utilization review organization.

3. The date that the requirement or restriction was removed in this state.

4. A method to access a standardized electronic prior authorization request transaction process.

(4) Any clinical review criteria on which a prior authorization requirement or restriction is based shall satisfy all of the following:

(a) The criteria are based on nationally recognized, generally accepted standards except where provided by law.

(b) The criteria are developed in accordance with the current standards of a national medical accreditation entity.

(c) The criteria ensure quality of care and access to needed health care services.

(d) The criteria are evidence-based.

(e) The criteria are sufficiently flexible to allow deviations from current standards when justified.

(f) The criteria are evaluated and updated when necessary and no less frequently than once every year.

(5) No health care plan may deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date that the service was provided.

(6) No health care plan nor any utilization review organization contracted with a health care plan may deem supplies or services as incidental or deny a claim for supplies or services if a provided health care service associated with the supplies or services receives prior authorization or if a provided health care service associated with the supplies or services does not require prior authorization.

(7) If a health care plan intends to impose a new prior authorization requirement or restriction or intends to amend a prior authorization requirement or restriction, the health care plan shall provide all providers contracted with the

health care plan advanced written notice of the new or amended requirement or restriction no less than 60 days before the new or amended requirement or restriction is implemented. The advanced written notice may be provided in an electronic format if the provider has agreed in advance to receive the notices electronically. No health care plan may implement a new or amended prior authorization requirement or restriction unless the health care plan or a contracted utilization review organization has updated the post on its website required under sub. (3) to reflect the new or amended prior authorization requirement or restriction.

(END)