



How It Works

- HB 176 requires state-regulated insurers (excluding Medicaid) to establish a prior authorization (PA) exemption program. This allows qualifying physicians to perform certain services without prior authorization.
- If granted an exemption, a physician may perform designated services without prior authorization.
- Exemption program requirements take effect January 1, 2028, though insurers may implement them earlier.
- Benefit plans not captured by this law include: Medicaid (could be added at a future date), Medicare, VA/TRICARE and ERISA plans.

Eligibility

- Based on your prior authorization performance over the previous 12 months (or shorter period as defined by insurer).
- Insurers cannot require more than a 93% approval rate to qualify.

Review & Notification

- Eligibility reviewed annually (at contract renewal or anniversary date).
- Insurers must notify you within 30 days of determination.
- Program requirements must be disclosed during contracting.

Insurer Discretion

- Legislation does not require:
 - Medicaid Managed Care Organizations (MCOs) to have an exemption program;
 - Inclusion of prescription drugs within an insurer's exemption program (although an insurer may choose to do so).
- Insurers may apply exemptions at the individual or group level; therefore, exemptions could be physician by physician or applied across entire practices.

Potential Participation Requirements

- Insurers may require one or more of the following:
 - Participation in value-based care arrangements;
 - In-network status (up to 1 year maximum);
 - Compliance with interoperability/EHR access standards.

Utilization Guardrails

- Insurers may set utilization thresholds, but:
 - Cannot require more than 24 requests per service;
 - Cannot set thresholds below 110% of the previous year's utilization rate.

Revocation of Exemption

- Exemptions may be revoked only if:
 - Evidence of fraud or abuse; or
 - Utilization reaches $\geq 110\%$ of the preceding year's levels per healthcare service.

If Approved

- A physician will receive notice confirming:
 - Eligibility for the exemption program;
 - The specific services that no longer require a prior authorization.

Transparency

- Establishes annual reporting requirements on prior authorization activity (approvals, denials, timelines) for both the state Medicaid program and the Department of Insurance, increasing transparency and accountability.
- Requires additional reporting on insurer exemption programs, providing insight into how these programs function for physicians and patients.
- Initial reports due: Medicaid by September 30, 2027, and Department of Insurance by September 30, 2028, with annual reporting required thereafter.