

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 611

BY HEALTH AND WELFARE COMMITTEE

AN ACT

1 RELATING TO HEALTH INSURANCE; AMENDING TITLE 41, IDAHO CODE, BY THE ADDITION
2 OF A NEW CHAPTER 35, TITLE 41, IDAHO CODE, TO ESTABLISH THE IDAHO PRIOR
3 AUTHORIZATION REFORM ACT, TO PROVIDE A SHORT TITLE, TO PROVIDE THE PUR-
4 POSE OF THE CHAPTER, TO DEFINE TERMS, TO PROVIDE FOR DISCLOSURE AND RE-
5 VIEW OF PRIOR AUTHORIZATION REQUIREMENTS, TO PROVIDE FOR STANDARDIZED
6 ELECTRONIC PRIOR AUTHORIZATIONS, TO PROVIDE FOR STANDARD PRIOR AUTHO-
7 RIZATIONS, TO PROVIDE FOR EXPEDITED PRIOR AUTHORIZATIONS, TO PROVIDE
8 FOR NOTIFICATIONS FOR ADVERSE DETERMINATIONS, TO PROVIDE FOR PERSON-
9 NEL QUALIFIED TO REVIEW APPEALS, TO PROVIDE FOR INSURER REVIEW OF PRIOR
10 AUTHORIZATION REQUIREMENTS, TO PROVIDE FOR REVOCATION OF PRIOR AUTHO-
11 RIZATIONS, TO PROVIDE FOR THE LENGTH OF APPROVALS, TO PROVIDE FOR AP-
12 PROVALS FOR CHRONIC CONDITIONS, TO PROVIDE FOR CONTINUITY OF PRIOR AP-
13 PROVALS, TO PROVIDE FOR THE EFFECT OF AN INSURER'S FAILURE TO COMPLY,
14 TO PROVIDE FOR ENFORCEMENT AND ADMINISTRATION, TO PROVIDE FOR REPORTS
15 TO THE DEPARTMENT OF INSURANCE, TO PROVIDE FOR FALSE REQUESTS FOR PRIOR
16 AUTHORIZATION, AND TO PROVIDE RULEMAKING AUTHORITY; AND DECLARING AN
17 EMERGENCY AND PROVIDING AN EFFECTIVE DATE.
18

19 Be It Enacted by the Legislature of the State of Idaho:

20 SECTION 1. That Title 41, Idaho Code, be, and the same is hereby amended
21 by the addition thereto of a NEW CHAPTER, to be known and designated as Chap-
22 ter 35, Title 41, Idaho Code, and to read as follows:

23 CHAPTER 35

24 IDAHO PRIOR AUTHORIZATION REFORM

25 41-3501. SHORT TITLE. This chapter shall be known and may be cited as
26 the "Idaho Prior Authorization Reform Act."

27 41-3502. PURPOSE. The purpose of this chapter is to:

28 (1) Protect the health care provider-patient relationship from unrea-
29 sonable third-party interference;

30 (2) Prevent prior authorization programs from hindering the indepen-
31 dent medical judgment of a physician or other health care provider; and

32 (3) Ensure the transparency of a fair and consistent process for health
33 care providers and their patients.

34 41-3503. APPLICABILITY AND SCOPE. This chapter applies to every
35 health benefit plan, as defined in section 41-5903, Idaho Code, to all
36 issuers of health benefit plans, and to all utilization reviews and utiliza-
37 tion review organizations, as defined in section 41-5903, Idaho Code, except
38 for employee or employer self-insured health benefit plans under the fed-
39 eral employee retirement income security act of 1974 or health care provided

1 pursuant to worker's compensation law. This chapter does not diminish the
 2 duties and responsibilities under other federal or state law or rules pro-
 3 mulgated under those laws applicable to a health insurer, health insurance
 4 issuer, health benefit plan, utilization review plan, or utilization review
 5 organization.

6 41-3504. DEFINITIONS. For the purposes of this chapter:

7 (1) "Adverse determination" means a determination by a health insur-
 8 ance issuer that, based on the information provided, a pre-service request
 9 for a benefit under the health insurance issuer's health benefit plan upon
 10 application of any utilization review technique does not meet the health
 11 insurance issuer's requirements for medical necessity, appropriateness,
 12 health care setting, level of care, or effectiveness or is determined to be
 13 experimental or investigational, and the requested benefit is therefore
 14 denied.

15 (2) "Appeal" means a formal request, either orally or in writing, to re-
 16 consider an adverse determination.

17 (3) "Approval" means a determination by a health insurance issuer that
 18 a health care service has been reviewed and, based on the information pro-
 19 vided, satisfies the health insurance issuer's requirements for medical ne-
 20 cessity and appropriateness.

21 (4) "Clinical review criteria" means the written screening procedures,
 22 decision abstracts, clinical protocols, and practice guidelines used by a
 23 health insurance issuer to determine the necessity and appropriateness of
 24 health care services.

25 (5) "Department" means the Idaho department of insurance.

26 (6) "Emergency medical condition" means a medical condition manifest-
 27 ing itself by acute symptoms of sufficient severity, including but not lim-
 28 ited to severe pain, such that a prudent layperson who possesses an average
 29 knowledge of health and medicine could reasonably expect the absence of im-
 30 mediate medical attention to result in:

31 (a) Placing the health of the individual or, with respect to a pregnant
 32 woman, the health of the woman or her unborn child, in serious jeopardy;

33 (b) Serious impairment to bodily functions; or

34 (c) Serious dysfunction of any bodily organ or part.

35 (7) "Emergency services" means health care items and services fur-
 36 nished or required to evaluate and treat an emergency medical condition.

37 (8) "Enrollee" means any person and the person's dependents enrolled in
 38 or covered by a health care plan.

39 (9) (a) "Expedited prior authorization request" means a pre-service or
 40 concurrent care claim for medical care or treatment for which applica-
 41 tion of the time periods for making a non-expedited prior authorization
 42 could, in the opinion of a treating health care professional or health
 43 care provider with knowledge of the enrollee's medical condition:

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

46 (ii) Subject the enrollee to severe pain that cannot be adequately
 47 managed without the care or treatment that is the subject of the
 48 authorization request; or

1 (iii) Lead to likely onset of an emergency medical condition if the
2 service is not rendered during the time period to render a prior
3 authorization determination for an urgent medical service.

4 (b) "Expedited prior authorization request" does not apply to emer-
5 gency services.

6 (10) "Health care professional" means a physician, a registered profes-
7 sional nurse, or another individual appropriately licensed or registered to
8 provide health care services.

9 (11) "Health care provider" means any physician, hospital, ambulatory
10 surgery center, or other person or facility that is licensed or otherwise au-
11 thorized to deliver health care services.

12 (12) "Health care service" means any services or level of services
13 included in the furnishing of medical care to an individual or the hospital-
14 ization incident to the furnishing of such care, as well as the furnishing of
15 any other services to any person for the purpose of preventing, alleviating,
16 curing, or healing human illness or injury, including behavioral health,
17 mental health, home health, and pharmaceutical services, products, and med-
18 ications.

19 (13) "Health insurance issuer" means the issuer of a health benefit
20 plan.

21 (14) "Medically necessary" means care that a health care professional
22 exercising prudent clinical judgment would provide to a patient for the pur-
23 pose of preventing, diagnosing, or treating an illness, injury, disease, or
24 its symptoms and that is:

25 (a) In accordance with generally accepted standards of medical prac-
26 tice;

27 (b) Clinically appropriate in terms of type, frequency, extent, site,
28 and duration and considered effective for the patient's illness, in-
29 jury, or disease;

30 (c) Focused on what is best for the patient's health outcome; and

31 (d) Not primarily for the convenience of the patient, treating physi-
32 cian, other health care professional, caregiver, family member, or
33 other interested party.

34 (15) "NCPDP SCRIPT standard" means the national council for prescrip-
35 tion drug programs SCRIPT standard version 2017071, or the most recent stan-
36 dard adopted by the United States department of health and human services.
37 Subsequently released versions of the NCPDP SCRIPT standard may be used.

38 (16) "Physician" means any person with a valid doctor of medicine, doc-
39 tor of osteopathy, or doctor of podiatry degree.

40 (17) "Prior authorization" means the process by which a health insur-
41 ance issuer determines the medical necessity and medical appropriateness of
42 an otherwise covered health care service before the rendering of such health
43 care service. While not requiring explicit approval, any notification re-
44 quired of an enrollee, health care professional, or health care provider by
45 the health insurance issuer before, at the time of, or concurrent to provid-
46 ing a health care service shall be included within the definition of "prior
47 authorization."

48 (18) "Utilization review organization" has the meaning given to that
49 term in section 41-5903, Idaho Code.

1 41-3505. DISCLOSURE AND REVIEW OF PRIOR AUTHORIZATION REQUIRE-
2 MENTS. (1) A health insurance issuer shall maintain a complete list of
3 services for which prior authorization is required, including for all ser-
4 vices where prior authorization is performed by an entity under contract
5 with the health insurance issuer.

6 (2) A health insurance issuer shall make any current prior authoriza-
7 tion requirements and restrictions, including the written clinical review
8 criteria, readily accessible and conspicuously posted on its website or
9 online portal to enrollees, health care professionals, and health care
10 providers. Content published by a third party and licensed for use by a
11 health insurance issuer may be made available through the health insurance
12 issuer's secure, password-protected website or online portal as long as the
13 access requirements of the website do not unreasonably restrict access.
14 Requirements shall be described in detail, written in easily understandable
15 language, and readily available to the health care professional and health
16 care provider at the point of care. The website or online portal shall indi-
17 cate for each service subject to prior authorization:

18 (a) The date on which prior authorization became required for policies
19 issued or health benefit plan documents delivered in Idaho, including
20 the effective dates and the termination dates, if applicable, in Idaho;

21 (b) The date on which the Idaho-specific requirement was listed on the
22 website or online portal of the health insurance issuer;

23 (c) If applicable, the date on which prior authorization requirement
24 was removed for Idaho; and

25 (d) If applicable, access to a standardized electronic prior autho-
26 rization request transaction process.

27 (3) The clinical review criteria must:

28 (a) Be consistent with nationally accepted standards generally recog-
29 nized by physicians and health care providers practicing in relevant
30 medical and clinical specialties except where state law provides its
31 own standard;

32 (b) Be developed in accordance with the current standards of a national
33 medical accreditation entity;

34 (c) Ensure quality of care and access to needed health care services;

35 (d) Be evidence-based on sources, including peer-reviewed scientific
36 studies;

37 (e) Be sufficiently flexible to allow deviations from norms when justi-
38 fied on a case-by-case basis; and

39 (f) Be evaluated and updated under the direction of a physician li-
40 censed in the relevant specialty at least annually.

41 (4) A health insurance issuer shall not deny a claim for failure to ob-
42 tain prior authorization if the prior authorization requirement was not in
43 effect on the date of service or if the claim or prior authorization require-
44 ments were not publicly disclosed by the plan on the health insurance is-
45 suer's website, online portal, or other materials.

46 (5) A health insurance issuer shall not deem as incidental or deny sup-
47 plies or health care services that are routinely used as part of a health care
48 service when:

49 (a) An associated health care service has received prior authoriza-
50 tion; or

1 (b) Prior authorization for the health care service is not required.

2 (6) If a health insurance issuer intends either to implement a new prior
3 authorization requirement or restriction or to amend an existing require-
4 ment or restriction, the health insurance issuer shall provide impacted
5 enrollees, contracted health care professionals, and contracted health care
6 providers of enrollees written notice of the new or amended requirement no
7 less than sixty (60) days before the requirement or restriction is imple-
8 mented. Written notice may take the form of a conspicuous notice posted on
9 the health insurance issuer's public website or online portal for contracted
10 health care professionals and contracted health care providers or email no-
11 tice to health care professionals or providers. A health insurance issuer
12 shall provide email notices to all impacted enrollees and to health care
13 professionals or health care providers if the health care professional or
14 health care provider has requested to receive the notice through email. A
15 new or amended requirement shall not be implemented unless the health insur-
16 ance issuer's website or online portal has been updated to reflect the new
17 or amended requirement or restriction. Written notice of a new, amended, or
18 restricted prior authorization requirement may be provided less than sixty
19 (60) days in advance of implementation if a health insurance issuer deter-
20 mines and contemporaneously notifies the department in writing that:

21 (a) The health insurance issuer has identified fraudulent or abusive
22 practices related to the health care service;

23 (b) The health care service is unavailable or scarce, necessitating the
24 use of an alternative health care service;

25 (c) The health care service is newly introduced to the health care mar-
26 ket and a delay in providing coverage for the health care service would
27 not be in the best interests of enrollees;

28 (d) The health care service is the subject of a clinical trial autho-
29 rized by the United States food and drug administration;

30 (e) Changes to the health care service or its availability are other-
31 wise required by law to be made by the health insurance issuer in less
32 than sixty (60) days; or

33 (f) The prior authorization requirement is being removed.

34 (7) Health insurance issuers using prior authorization shall make sta-
35 tistics available regarding prior authorization approvals and denials on
36 their website or online portal in a readily accessible format. Following
37 each calendar year, the statistics shall be updated annually by February 1,
38 and include all of the following information:

39 (a) A list of all health care services, including medications, that are
40 subject to prior authorization;

41 (b) The percentage of standard prior authorization requests that were
42 approved, aggregated for all items and services;

43 (c) The percentage of standard prior authorization requests that were
44 denied, aggregated for all items and services;

45 (d) The percentage of prior authorization requests that were approved
46 after appeal, aggregated for all items and services;

47 (e) The percentage of prior authorization requests for which the time
48 frame for review was extended, and the request was approved, aggregated
49 for all items and services;

1 (f) The percentage of expedited prior authorization requests that were
2 approved, aggregated for all items and services;

3 (g) The percentage of expedited prior authorization requests that were
4 denied, aggregated for all items and services;

5 (h) The average and median time that elapsed between the submission of a
6 request and a determination by the health insurance issuer for standard
7 prior authorization, aggregated for all items and services; and

8 (i) The average and median time that elapsed between the submission of
9 a request and a determination by the health insurance issuer for expedited
10 prior authorization, aggregated for all items and services.

11 41-3506. STANDARDIZED ELECTRONIC PRIOR AUTHORIZATIONS. (1) If a
12 health insurance issuer requires prior authorization of a health care ser-
13 vice, the issuer or its contracted utilization review organization shall,
14 by July 1, 2026, make available a standardized electronic prior authoriza-
15 tion request transaction process using an internet website, online portal,
16 or similar electronic, web-based system. After January 1, 2027, a health
17 insurance issuer shall accept and respond to prior authorization requests
18 under the pharmacy benefit through a secure electronic transmission using
19 the NCPDP SCRIPT standard electronic prior authorization transactions.

20 (2) No later than January 1, 2027, all health care professionals and
21 health care providers shall be required to use the standardized electronic
22 prior authorization request transaction process made available as required
23 by subsection (1) of this section.

24 (3) For purposes of this chapter, a prior authorization request shall
25 be considered received upon:

26 (a) Confirmation of electronic submission; or

27 (b) The next calendar day following submission if submitted outside of
28 normal business hours.

29 41-3507. STANDARD PRIOR AUTHORIZATIONS. If a health insurance issuer
30 requires prior authorization of a health care service, the health insurance
31 issuer shall make an approval or adverse determination and notify the en-
32 rollee and the enrollee's health care professional or health care provider
33 of the approval or adverse determination as expeditiously as the enrollee's
34 condition requires but no later than five (5) calendar days after obtaining
35 all necessary information to make the approval or adverse determination,
36 unless a longer minimum time frame is required under federal law for the
37 health insurance issuer and the health care service at issue. Requests for
38 information must be reasonably necessary to adjudicate the prior authoriza-
39 tion request. As used in this section, "necessary information" includes the
40 results of any face-to-face clinical evaluation, second opinion, or other
41 clinical information that is directly applicable to the requested service
42 that may be required. Provided, however, health insurance issuers shall
43 respond within two (2) business days for prior authorization requests for
44 pharmaceutical services and products.

45 41-3508. EXPEDITED PRIOR AUTHORIZATIONS. (1) If requested by a treat-
46 ing health care professional or health care provider for an enrollee, a
47 health insurance issuer shall render an approval or adverse determination

1 concerning urgent health care services and notify the enrollee and the en-
2 rollee's health care professional or health care provider of that approval
3 or adverse determination as expeditiously as the enrollee's condition
4 requires but no later than twenty-four (24) hours after receiving all infor-
5 mation needed to complete the review of the requested health care services
6 unless a longer minimum time frame is required under federal law for the
7 health insurance issuer and the urgent health care service at issue.

8 (2) To facilitate the rendering of a prior authorization determina-
9 tion pursuant to this section, a health insurance issuer shall establish a
10 mechanism to ensure health care professionals have access to appropriately
11 trained and licensed physicians of the same specialty for consultation,
12 designated by the issuer to make such determinations for prior authorization
13 concerning urgent care services.

14 41-3509. NOTIFICATIONS FOR ADVERSE DETERMINATIONS. If a health in-
15 surance issuer makes an adverse determination, the health insurance issuer
16 shall include the following in the notification to the enrollee and the en-
17 rollee's health care professional or health care provider:

18 (1) The reasons for the adverse determination and related evi-
19 dence-based criteria, including a description of any missing or insuffi-
20 cient documentation;

21 (2) The right to appeal the adverse determination;

22 (3) Instructions on how to file the appeal;

23 (4) Additional documentation necessary to support the appeal; and

24 (5) The right to request an independent external review pursuant to the
25 provisions of chapter 59, title 41, Idaho Code.

26 41-3510. PERSONNEL QUALIFIED TO REVIEW APPEALS. A health insurance
27 issuer shall ensure that all appeals are reviewed by a physician when the
28 request is made by a physician or a representative of a physician. The re-
29 viewing physician shall:

30 (1) Possess a current and valid nonrestricted license to practice
31 medicine with substantially similar licensing requirements to this state;

32 (2) Be certified by the American board of medical specialties or the
33 American osteopathic association within the relevant specialty of a physi-
34 cian who typically manages the medical condition or disease;

35 (3) Have training, knowledge, or experience of providing the health
36 care services under appeal;

37 (4) Not have been directly involved in making the adverse determina-
38 tion; and

39 (5) Consider all known clinical aspects of the health care service un-
40 der review, including a review of all pertinent medical records provided to
41 the health insurance issuer or health care provider, the health plan's clin-
42 ical guidelines, and peer-reviewed scientific studies.

43 41-3511. INSURER REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. A health
44 insurance issuer shall periodically review its prior authorization require-
45 ments and consider removal of prior authorization requirements.

1 41-3512. REVOCATION OF PRIOR AUTHORIZATIONS. (1) A health insurance
2 issuer may not revoke or further limit, condition, or restrict a previously
3 issued prior authorization approval while it remains valid in accordance
4 with this chapter unless:

5 (a) The health insurance issuer has identified fraudulent or abusive
6 practices related to the health care service;

7 (b) The health care service is unavailable, necessitating the use of an
8 alternative health care service;

9 (c) The health care service is the subject of a new safety alert from the
10 United States food and drug administration or is in response to a public
11 health emergency;

12 (d) The change is based on nationally recognized generally accepted
13 standards developed in accordance with current standards of a national
14 medical accreditation entity or specialty society; or

15 (e) Changes to the health care service or its availability are other-
16 wise required by law to be made by the health insurance issuer within
17 sixty (60) days.

18 (2) Notwithstanding any other provision of law, if a claim is properly
19 coded and submitted timely to a health insurance issuer, the health insur-
20 ance issuer shall make payment according to the terms of coverage on claims
21 for health care services for which prior authorization was required and ap-
22 proval received before the provision of health care services unless:

23 (a) It is determined that the enrollee's health care professional or
24 health care provider knowingly and without exercising prudent clinical
25 judgment provided health care services that required prior authoriza-
26 tion from the health insurance issuer or its contracted utilization re-
27 view organization without first obtaining prior authorization for such
28 health care services;

29 (b) It is timely determined that the health care services claimed were
30 not performed;

31 (c) It is timely determined that the health care services provided by
32 the enrollee's health care provider or health care professional were
33 contrary to the instructions of the health insurance issuer or its con-
34 tracted utilization review organization if contact was made between
35 such parties before the service being provided;

36 (d) It is timely determined that the person receiving such health care
37 services was not an enrollee of the health care plan; or

38 (e) The approval was based on a material misrepresentation by the en-
39 rollee, health care professional, or health care provider. As used in
40 this paragraph, "material" means a fact or situation that would have re-
41 sulted in a substantial change in the determination had it been accu-
42 rately disclosed in the submission.

43 (3) Nothing in this section shall preclude a utilization review organi-
44 zation or a health insurance issuer from performing post-service reviews of
45 health care claims for purposes of payment integrity or for the prevention of
46 fraud, waste, or abuse.

47 41-3513. LENGTH OF APPROVALS. (1) A prior authorization approval
48 shall be valid for twelve (12) months after the date the health care profes-
49 sional or health care provider receives the prior authorization approval.

1 Provided, however, a health insurance issuer and an enrollee or enrollee's
2 health care professional may extend a prior authorization approval for a
3 longer period, by agreement. All dosage increases shall be based on estab-
4 lished evidentiary standards, and nothing in this section shall prohibit
5 a health insurance issuer from having safety edits in place. This section
6 shall not apply to the prescription of benzodiazepines or schedule II nar-
7 cotic drugs, such as opioids.

8 (2) Nothing in this section shall require a policy or plan to cover any
9 care, treatment, or services for any health condition that the terms of cov-
10 erage otherwise completely exclude from the policy's or plan's covered ben-
11 efits without regard for whether the care, treatment, or services are medi-
12 cally necessary.

13 41-3514. APPROVALS FOR CHRONIC CONDITIONS. (1) If a health insurance
14 issuer requires a prior authorization for a recurring health care service
15 or maintenance medication for the treatment of a chronic or long-term condi-
16 tion, including but not limited to chemotherapy for the treatment of cancer,
17 the approval shall remain valid for the lesser of twelve (12) months from the
18 date the health care professional or health care provider receives the au-
19 thorization approval or the length of the treatment as determined by the pa-
20 tient's health care professional. Provided, however, a health insurance is-
21 suer and an enrollee or the enrollee's health care professional may extend a
22 prior authorization approval for a longer period, by agreement. This sec-
23 tion shall not apply to the prescription of benzodiazepines or schedule II
24 narcotic drugs, such as opioids.

25 (2) Nothing in this section shall require a policy or plan to cover any
26 care, treatment, or services for any health condition that the terms of cov-
27 erage otherwise completely exclude from the policy's or plan's covered ben-
28 efits without regard for whether the care, treatment, or services are medi-
29 cally necessary.

30 41-3515. CONTINUITY OF PRIOR APPROVALS. (1) Upon receipt of informa-
31 tion documenting a prior authorization approval from the enrollee or from
32 the enrollee's health care professional or health care provider, a health
33 insurance issuer shall honor a prior authorization granted to an enrollee
34 from a previous health insurance issuer for at least the initial ninety (90)
35 days of an enrollee's coverage under a new health plan, subject to the terms
36 of the enrollee's coverage agreement.

37 (2) During the time period described in subsection (1) of this section,
38 a health insurance issuer may perform its own review to grant a prior autho-
39 rization approval, subject to the terms of the enrollee's coverage agree-
40 ment.

41 (3) If there is a change in coverage of or approval criteria for a pre-
42 viously authorized health care service, the change in coverage or approval
43 criteria does not affect an enrollee who received prior authorization before
44 the effective date of the change for the remainder of the enrollee's plan
45 year.

46 (4) Except to the extent required by medical exceptions processes for
47 prescription drugs, nothing in this section shall require a policy or plan
48 to cover any care, treatment, or services for any health condition that the

1 terms of coverage otherwise completely exclude from the policy's or plan's
2 covered benefits without regard for whether the care, treatment, or services
3 are medically necessary.

4 41-3516. EFFECT OF INSURER'S FAILURE TO COMPLY. A failure by a health
5 insurance issuer to comply with the deadlines and other requirements speci-
6 fied in this chapter shall result in any health care services subject to re-
7 view to be automatically deemed authorized by the health insurance issuer or
8 its contracted utilization review organization.

9 41-3517. ENFORCEMENT AND ADMINISTRATION. (1) In addition to the en-
10 forcement powers granted to it by law to enforce the provisions of this chap-
11 ter, the department is granted specific authority to issue a cease-and-de-
12 sist order or require a utilization review organization or health insurance
13 issuer, or both, to submit a plan of correction for violations of this chap-
14 ter. Subject to rules promulgated by the department pursuant to chapter 52,
15 title 67, Idaho Code, and after proper notice and the opportunity for a hear-
16 ing, the department may impose on a utilization review organization, health
17 benefit plan, or health insurance issuer an administrative fine not to ex-
18 ceed ten thousand dollars (\$10,000) per violation for failure to submit a re-
19 quested plan of correction, failure to comply with its plan of correction,
20 or repeated violations of this chapter. All fines collected by the depart-
21 ment pursuant to this section shall be deposited in the state general fund.
22 The department may also exercise all authority granted to it under the pro-
23 visions of chapter 59, title 41, Idaho Code, to deny or revoke approval of a
24 utilization review organization for a violation of this chapter.

25 (2) An enrollee or an enrollee's health care provider who has evidence
26 that the enrollee's health insurance issuer or health benefit plan is in
27 violation of the provisions of this chapter may file a complaint with the
28 department. The department shall review all complaints received and in-
29 vestigate all complaints that it deems to state a potential violation. The
30 department shall fairly, efficiently, and timely review and investigate
31 complaints and shall provide the subject of the complaint an opportunity to
32 refute the evidence against it. Health insurance issuers, health benefit
33 plans, and utilization review organizations found to be in violation of this
34 chapter shall be penalized in accordance with this section.

35 (3) There shall be no private right of action under this chapter.

36 41-3518. REPORTS TO THE DEPARTMENT. (1) By June 1, 2027, and each June
37 1 thereafter, a health insurance issuer shall report to the department, on a
38 form issued by the department, the following aggregated trend data, de-iden-
39 tified of protected health information, related to the insurer's practices
40 and experience for the prior plan year for health care services submitted for
41 payment:

- 42 (a) The number of prior authorization requests;
43 (b) The percentage of prior authorization requests denied;
44 (c) The percentage of prior authorization appeals received;
45 (d) The percentage of adverse determinations reversed on appeal;
46 (e) The percentage of prior authorization requests that were not sub-
47 mitted electronically;

1 (f) As a percentage by service, the ten (10) health care services that
2 were most frequently denied through prior authorization; and

3 (g) The five (5) reasons prior authorization requests were most fre-
4 quently denied.

5 (2) All reports required by this section shall be considered public
6 records pursuant to chapter 1, title 74, Idaho Code, and the department shall
7 make all reports freely available to requestors and post all reports to its
8 public website without redactions.

9 41-3519. FALSE REQUESTS FOR PRIOR AUTHORIZATION. If a health insur-
10 ance issuer has clear and convincing evidence that a health care profes-
11 sional or health care provider has knowingly and willfully submitted false
12 or fraudulent requests for prior authorization to the health insurance is-
13 suer, the issuer shall notify and provide that information to the department
14 director. After receipt of such notification and information, the director
15 shall forward these reports to the board of medicine or such other licensing
16 agency with oversight of the health care provider and to the office of the
17 prosecuting authority having jurisdiction.

18 41-3520. RULES. The department shall have the authority to promulgate
19 rules, subject to legislative approval, pursuant to the provisions of chap-
20 ter 52, title 67, Idaho Code, to govern the administration of this chapter.

21 SECTION 2. An emergency existing therefor, which emergency is hereby
22 declared to exist, this act shall be in full force and effect on and after
23 July 1, 2026.