SENATE BILL 315:
More Transparency/Efficiency in Utiliz. Rev.

2025-2026 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 18, 2025
Introduced by:	Sens. Burgin, Galey, Sawrey	**Prepared by:**	Jason Moran-Bates
Analysis of:	First Edition		Committee Staff

OVERVIEW: Senate Bill 315 would establish timelines for insurers to notify insureds of utilization reviews for urgent health care services, require qualified physicians to conduct appeals of initial utilization review denials, require insurers to post utilization review requirements on their websites before those requirements can be effective, and ensure prior utilization review results remained effective if insureds switched to a new plan with the same insurer.

CURRENT LAW: Under current law, insurers must notify insureds of the results of a utilization review within three business days. There is no distinction between reviews for urgent and non-urgent procedures.

BILL ANALYSIS: Senate Bill 315 would change the insurance utilization review process regulations in Chapter 58 (Insurance) as follows:

- Insurers must notify insureds and their providers of the utilization review result within 24 hours of receiving all necessary information for urgent services via electronic health records and within 3 days for non-urgent services and urgent services where information is not submitted via electronic health records.
- Utilization review appeals must be reviewed by a (i) licensed physician with three years' experience in the same or a similar specialty as the treating physician or (ii) a licensed physician with training and experience treating the medical condition at issue. The reviewing physician cannot have any prior involvement with the case or financial interest in the outcome.
- Mental health appeals submitted by a non-physician provider may be reviewed by a licensed non-physician mental health provider.
- All clinical aspects, including literature submitted by the treating physician, must be considered in the utilization review appeals process.
- Utilization review requirements must be readily available on the insurer's website, and utilization review requirement changes may not be effective until they have been posted on the insurer's website.
- Prior authorizations that have been approved will remain in force for 90 days after an insured switches to a new health benefit plan offered by the same insurer. If the authorization is for a chronic condition, the prior authorization will remain in force for at least six months.
- Effective January 1, 2028, insurers must provide utilization review application programming interfaces that comply with the requirements of 45 CFR §156.223(b) as it existed on January 1, 2025.

- Insurers would be prohibited from using an AI-based algorithm as the sole basis for a utilization review determination.

The State Treasurer and the Executive Administrator of the State Health Plan would be required to ensure the State Health Plan's compliance with all these provisions by the next plan year.

EFFECTIVE DATE: The bill would become effective October 1, 2026, and apply to contracts issued, renewed, or amended on or after that date. The provisions dealing the with the compliance of the State Health Plan would be effective when they become law.