Fall 2026 Regulatory Updates

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Featured Speakers



Aja Leichliter

Vice President and Chief Compliance Officer

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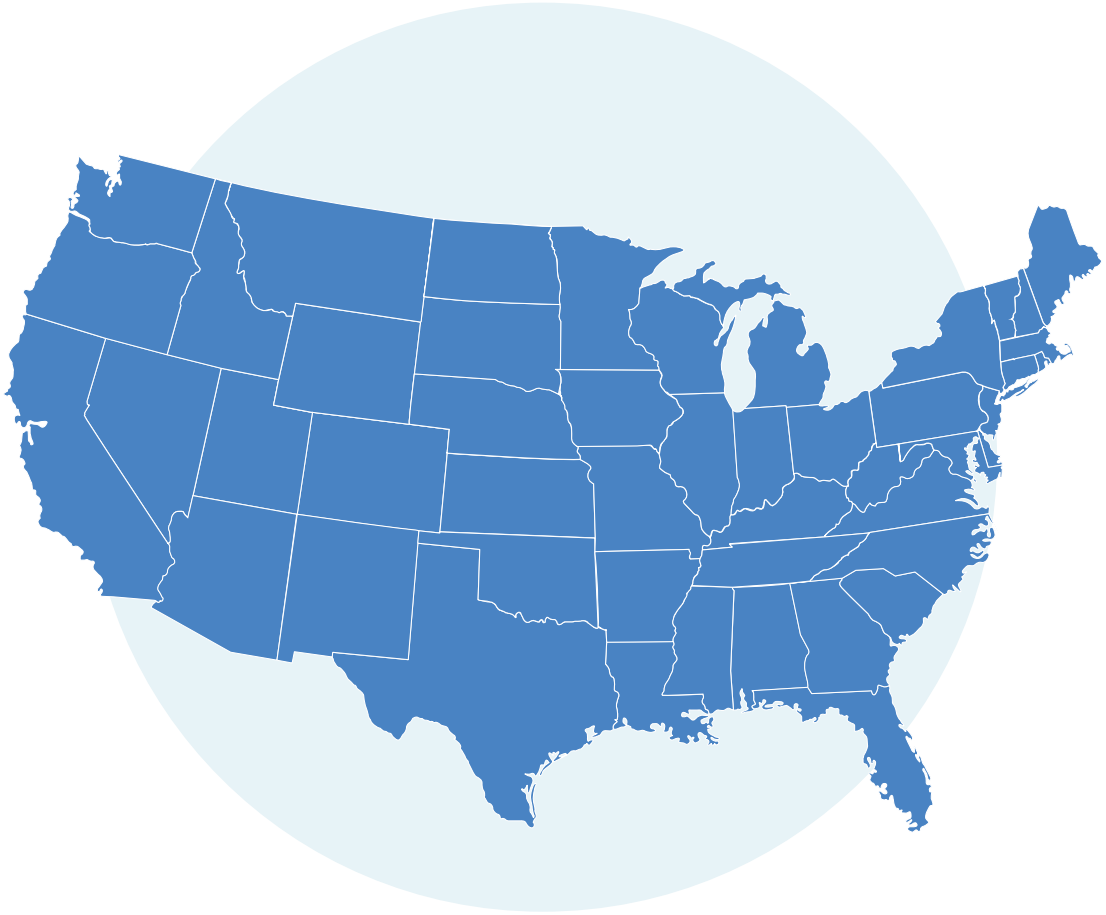
Please note: *The information presented today is not intended to be legal advice. Please consult your legal counsel for legal interpretation of any legislation or regulation.*

MRIoA encourages you to read through the bills in their ***entirety*** *to determine if there are additional requirements that may be applicable to your organization.*

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MRIoA Regulatory Monitoring™ - Trends To Watch



Artificial Intelligence (AI)

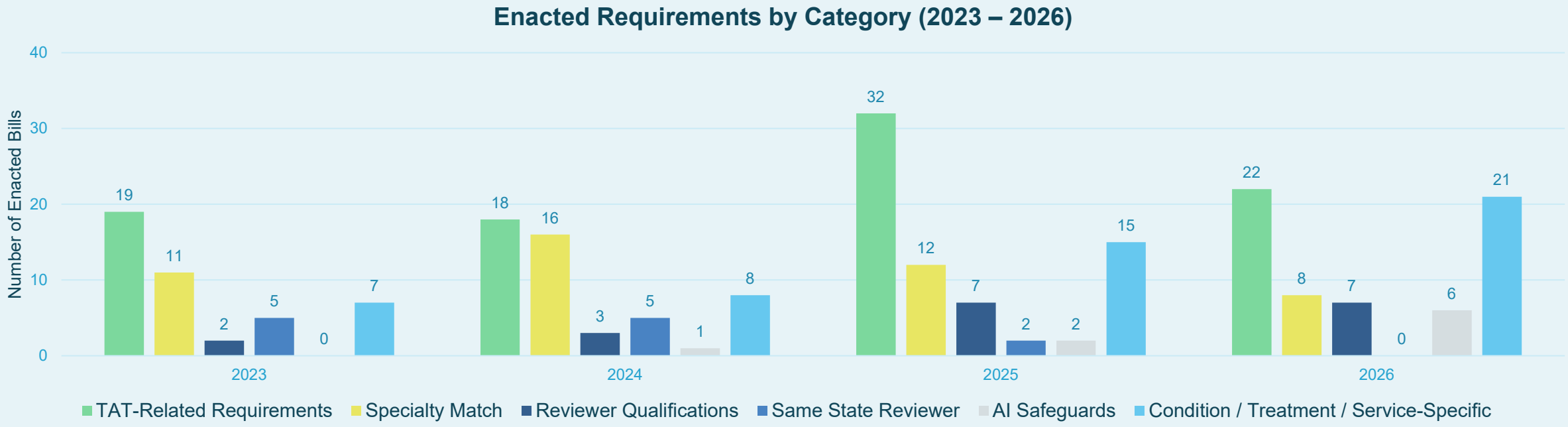
Prior Authorization

Reviewer Qualifications/ Specialty Match

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Enacted Requirement Trends

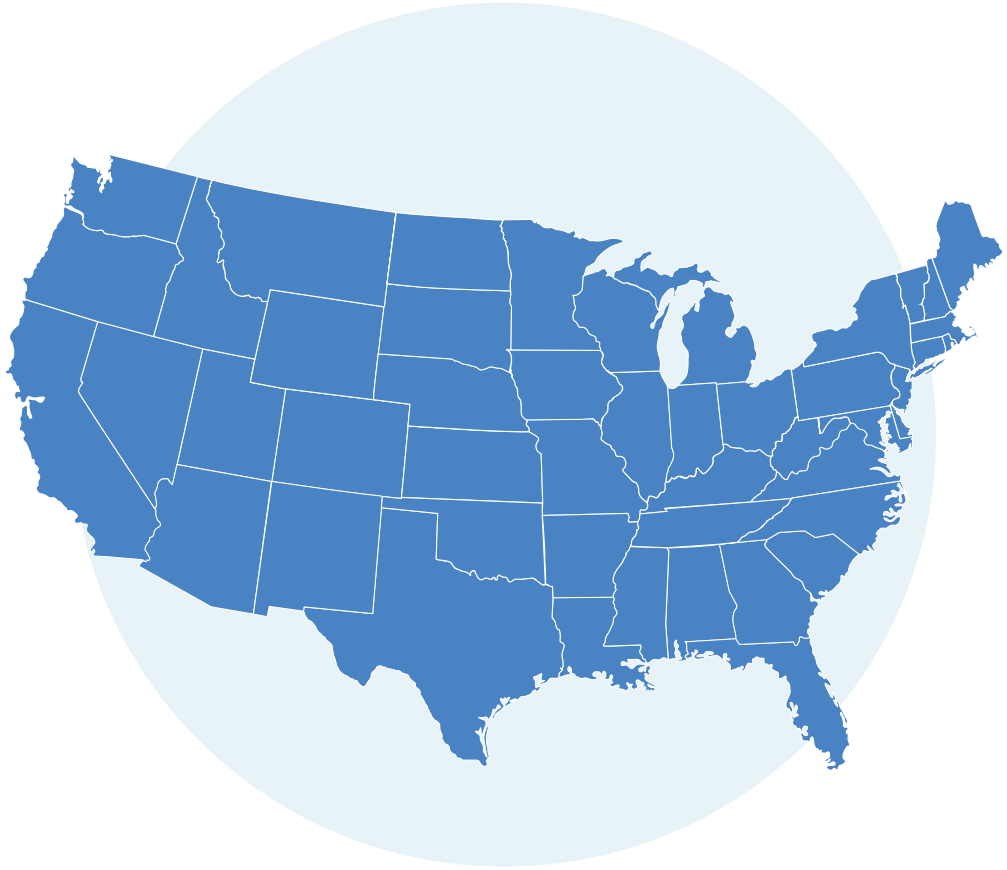


- **TAT mandates lead**, peaking in 2025 and remaining elevated in 2026.
- **Condition-, treatment-, and service-specific mandates surged**, reaching 21 in 2026.
- **AI safeguards are accelerating**, rising from zero in 2023 to six in 2026.
- **Reviewer mandates are flattening,** with specialty-match activity declining and no new same-state requirements in 2026.

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Legislation Effective on 1/1/2027



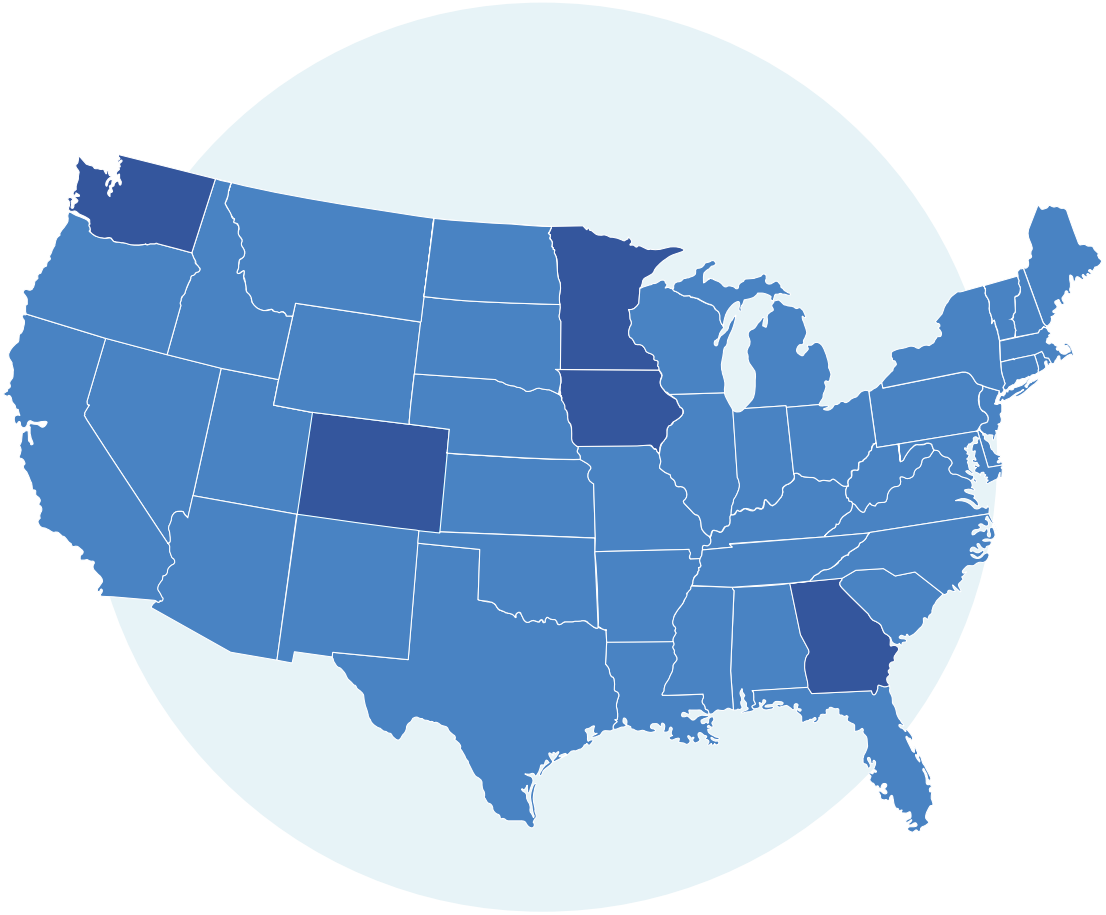
16 States

- **AL**: Prior Auth, UR, Step Therapy, Specialty Match, RX
- **CA**: Prior Auth
- **CO**: AI, UR, RX
- **DE**: Prior Auth, UR, Specialty Match, Reviewer Qualifications, RX
- **GA**: AI, UR, RX
- **IA**: Prior Auth, UR, AI, Specialty Match, Reviewer Qualifications, RX
- **IL**: Prior Auth, Criteria, RX
- **KY**: Prior Auth, UR, Gold Card
- **LA**: Prior Auth, RX
- **MN**: AI, UR, RX
- **NH**: Prior Auth, Step Therapy, RX
- **NM**: Prior Auth, RX
- **NY**: Prior Auth, UR, RX
- **OR**: Prior Auth
- **VA**: Prior Auth, UR, Reviewer Qualifications, Notice Information, RX
- **WA**: Prior Auth, RX

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Artificial Intelligence Legislation

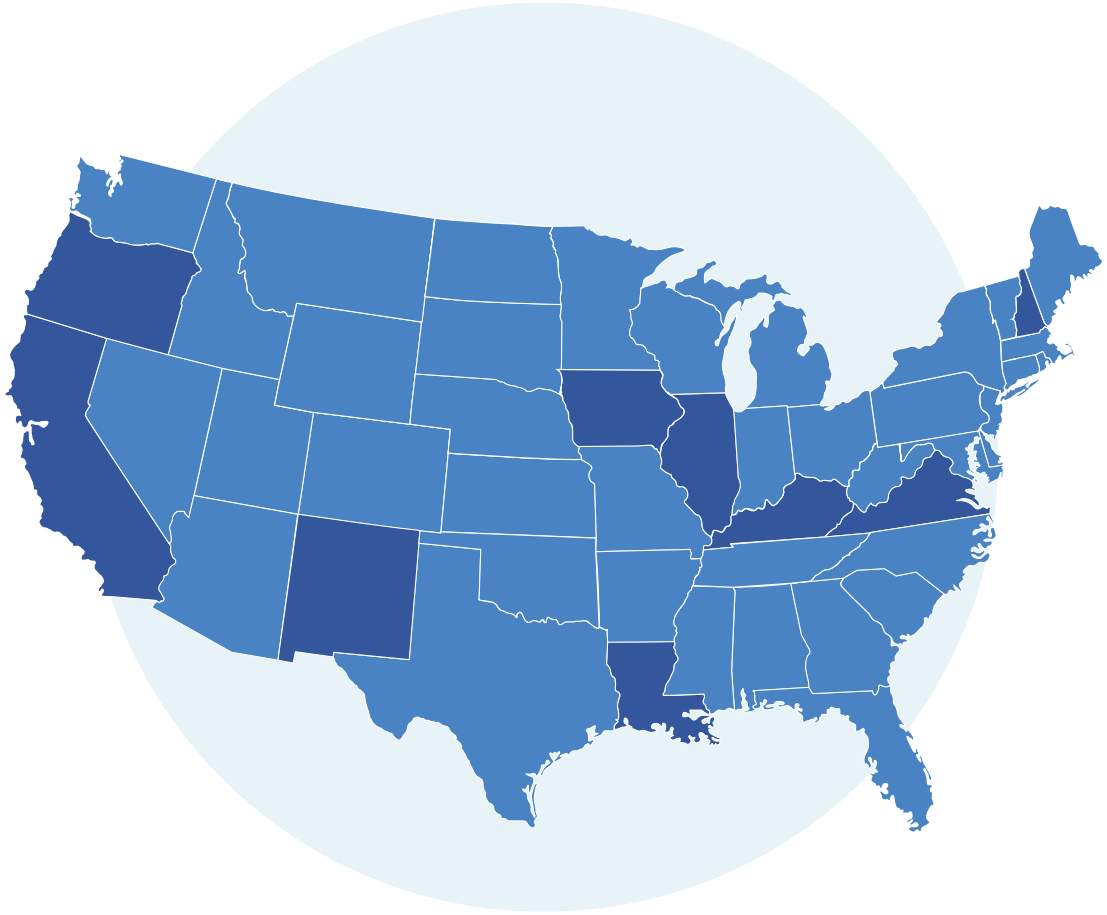
5 States

- Entities using AI systems for UR/PA must ensure determinations are based on individual medical history and clinical circumstances
- Adverse determinations must be reviewed by a clinical peer
- Ethical AI practices – may not be used for decision making

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Prior Authorization – Specialty Coverage

9 States

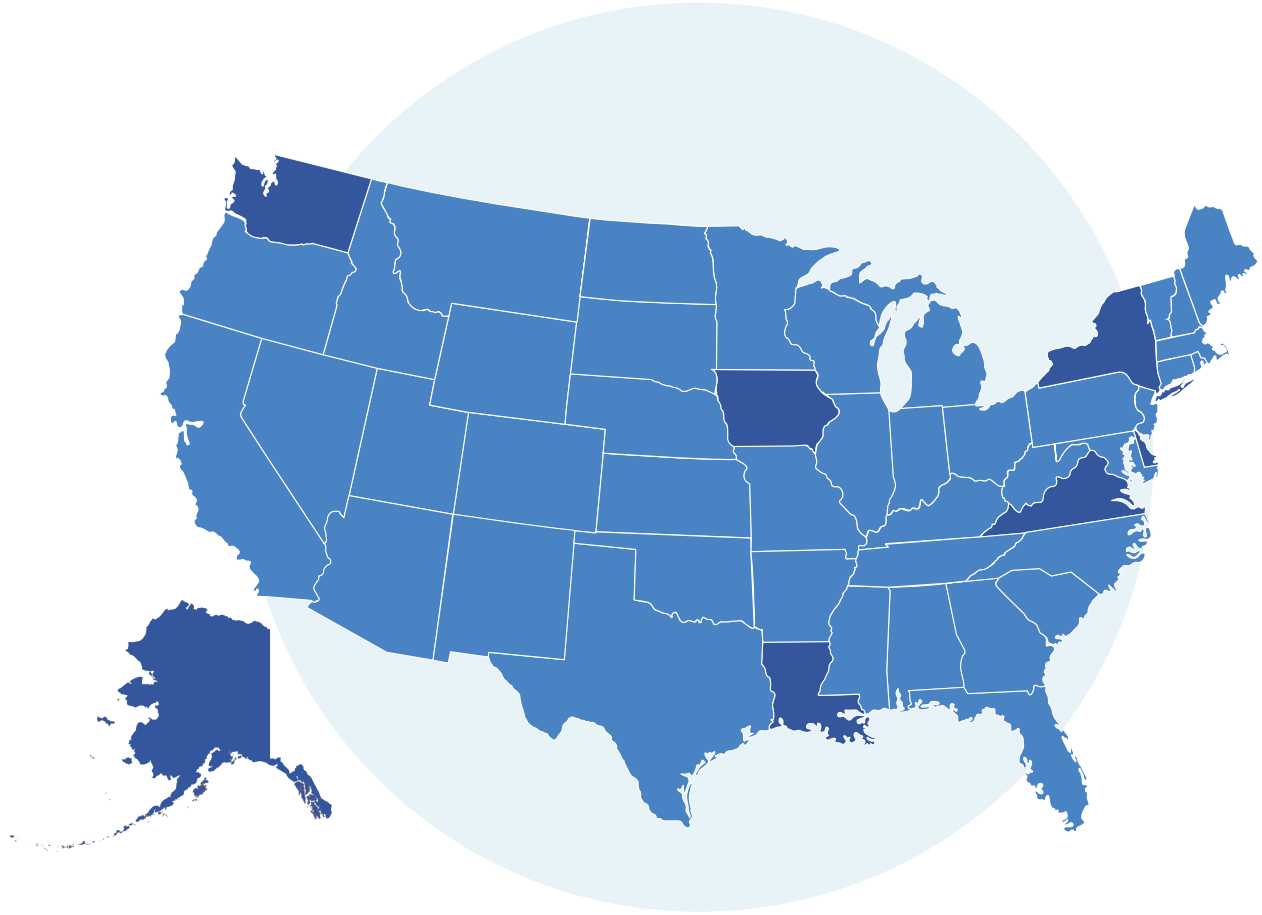
- PAs prohibited for mental health crises, cancer screenings, hepatitis C, HIV/AIDS, hereditary bleeding disorders, prosthetic and orthotic devices, acquired brain injuries, and menopause/perimenopause

- Carriers must provide adequate coverage and access to a broad spectrum of pain management services

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Prior Authorization Legislation

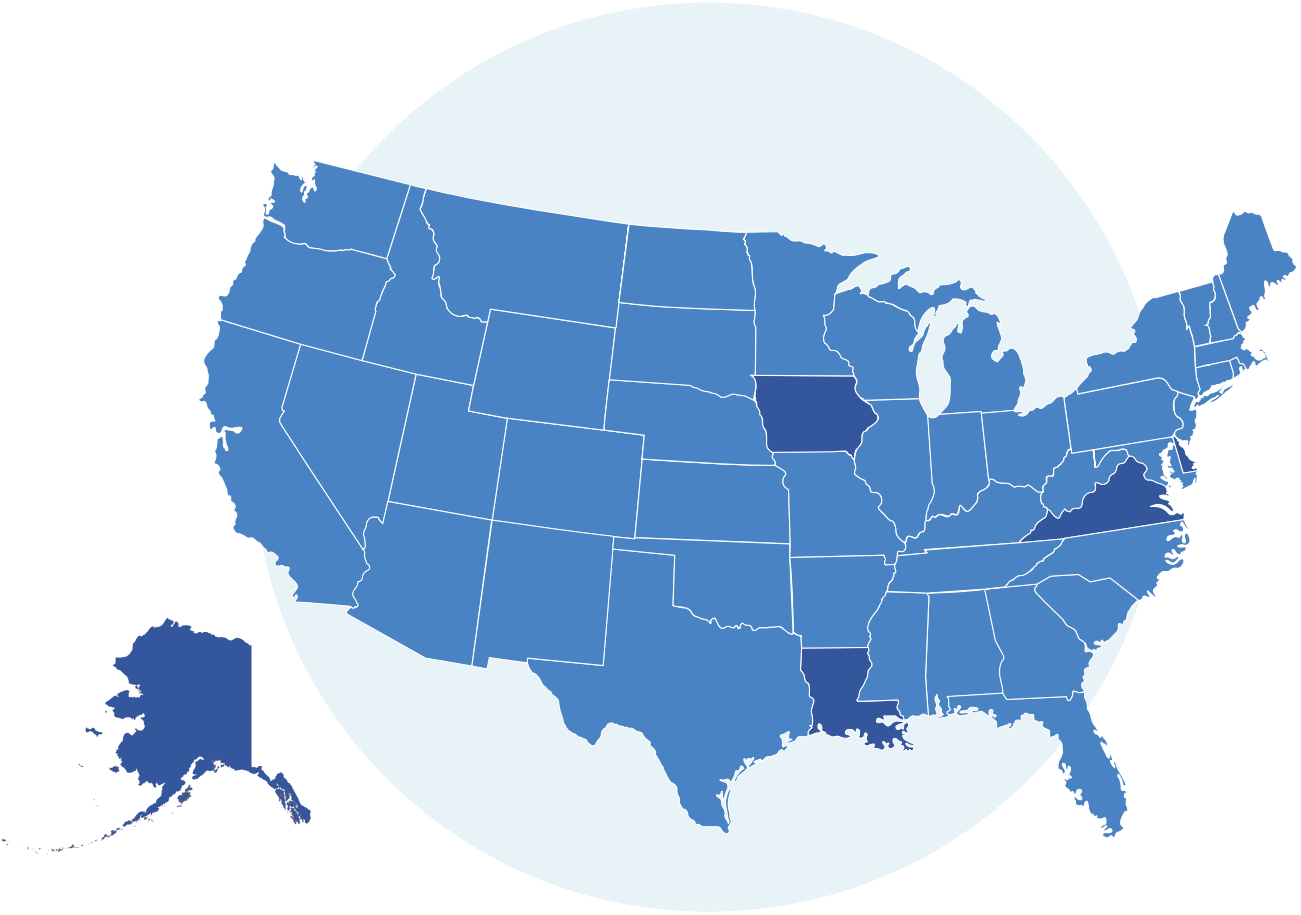
6 States

- PA TATs: Standard 3-5 business days, Urgent 24-72 hours
- Alternate process of eliminating PAs for services with high PA approval rate and electronic PA processes
- Carriers must submit PA data to the DOIs annually and must publish a list of services requiring PA on publicly accessible website

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Reviewer Qualifications/ Specialty Match

5 States

- Adverse determinations must be made by a licensed physician in the same/similar specialty who has the training and expertise to treat the specific medical condition/manages the service under review OR non-physician provider requests must be performed by a provider in the same/similar profession

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Next Steps

- Look for regulatory updates from MRIoA
  - https://www.mrioa.com/services/regulatory-guidance/
- Next round table discussions
  - May 2027

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Thank you

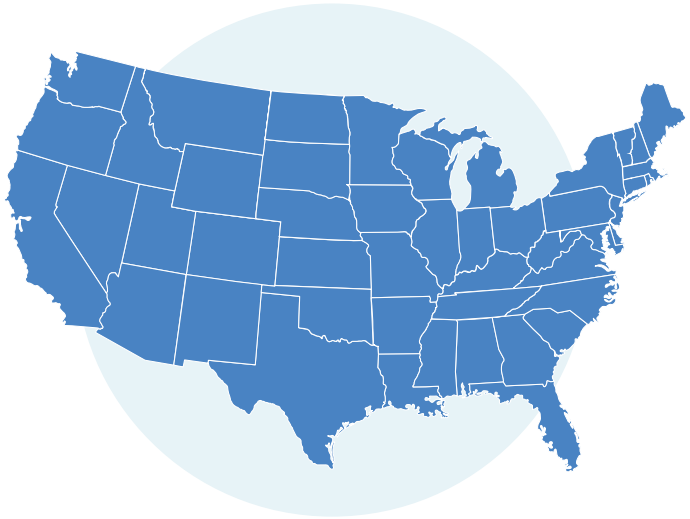
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Regulatory Changes – Alaska



Prior Auth, UR, Step Therapy, Specialty Match, RX

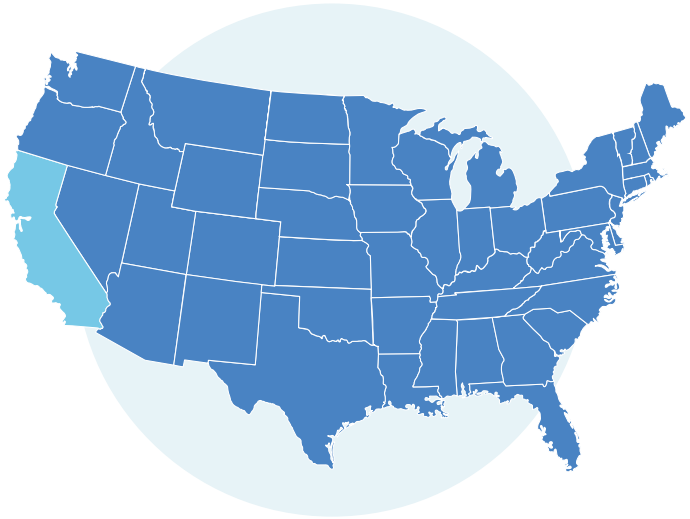
S.B. 133: Applicable to fully insured Alaska health plans and TPAs and PBMs that administer those plans

- A provider may request a specialty matched clinical peer review of any PA request
- The peer reviewer must attest that they considered all medical notes and relevant clinical information submitted as part of the PA request.
- Insurers must establish an ePA process that meets the CMS interoperability and patient access rules.
- Prior Auth TATs:
    - Standard: 72 business hours for requests submitted by fax; 72 calendar hours for requests submitted by any other method
    - Urgent: 24 hours
- Insurers must establish a step therapy exception process if it uses step therapy protocols.

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Regulatory Changes – California



Prior Auth

A.B. 1843: Applies to Fully insured CA, Medicaid, HMOs

Prohibits a health care plan from subjecting direct-acting antiviral drugs that are medically necessary for the treatment of hepatitis C to PAs. Specifies that these provisions do not require a health care plan to cover all therapeutically equivalent versions without PA.

A.B. 950: Applies to Fully insured CA

Health plans must include coverage for all medically necessary treatments or medications, as determined by a health care provider, approved by the FDA for the treatment of Alzheimer's disease or other medical conditions affecting memory

S.B. 964: Applies to Fully insured CA

Allows a provider to submit a written request to adjust the dose or frequency for a serious chronic condition or cancer treatment if it was previously approved drug to meet a patients needs without PA. TAT of 72 hours.

S.B. 1023: Applies to Fully insured CA, Medicaid

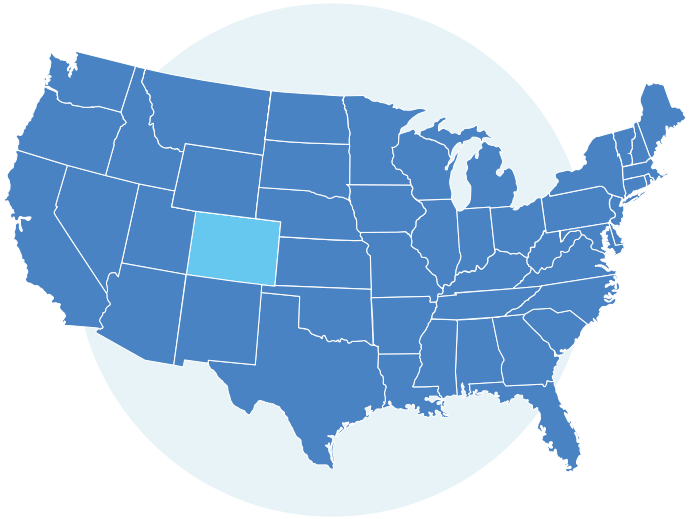
Prohibits health plans from requiring PAs/step therapy for antiretroviral drugs, drug devices, or drug products medically necessary for the prevention of HIV/AIDS, provided that at least one therapeutically equivalent version is covered without such restrictions and must be covered under both the medical benefit and the prescription drug benefit.

S.B. 1094: Applies to Fully insured CA, PBMs

Prohibits a PBM/health plan from limiting/excluding coverage for a drug that was previously approved for coverage if an insured continues to be prescribed that drug and the drug is appropriately prescribed and is considered safe and effective for treating the medical condition.

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Regulatory Changes – Colorado



AI, UR, RX

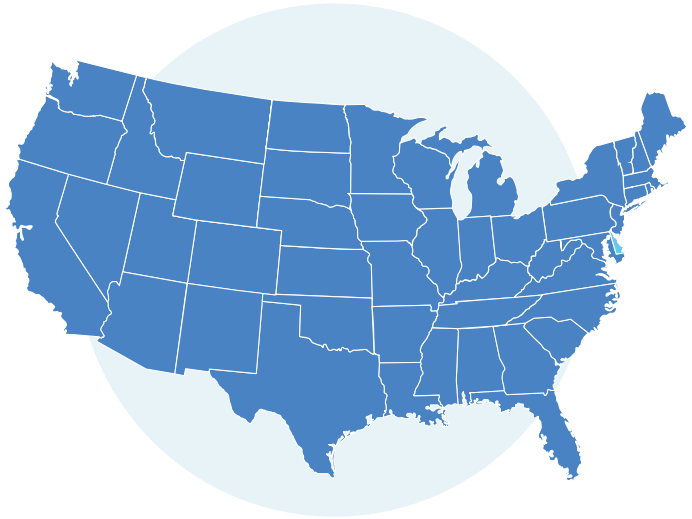
H.B. 1139:

- Health insurance carriers, PBMs, UROs, behavioral health administrative services organizations, and managed care entities using AI systems for utilization review must ensure determinations are based on individual medical history and clinical circumstances, are not solely on group data, and adverse determinations must be reviewed by licensed clinicians.

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Regulatory Changes – Delaware



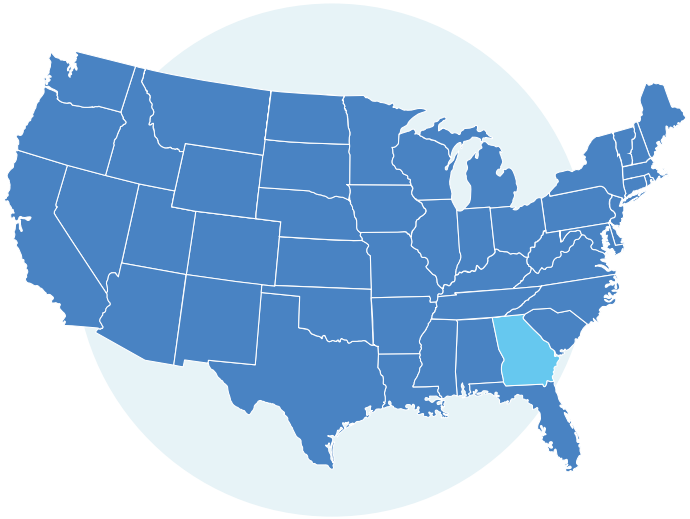
Prior Auth, UR, Specialty Match, Reviewer Qualifications, RX

S.B. 12: Applicable to fully Delaware insured health plans and TPAs and PBMs that administer those plans

- For physician-submitted requests, adverse determinations must be made by a physician in the same or similar specialty that manages the service under review; or consults with a physician who meets those requirements;
- For non-physician provider requests, denials and appeal reviews must be performed by a provider in the same or similar profession, or in consultation with one.
- Appeal determinations must include a summary of supporting findings,
    - Reviewer qualifications (license, certification, specialty), and the connection between the patient's condition and the criteria used.
- UR entities must perform utilization review on weekends and provide access to a medical director or other clinical decision-maker Monday-Friday from 7:00 a.m. to 7:00 p.m. and during reasonable weekend business hours.
- PA TATs:
    - Standard: 3 business days (electronic requests) or 5 business days (non-electronic requests)
    - Urgent: 24 hours (electronic requests) or 48 hours (non-electronic requests)
    - Pharmaceuticals: 2 business days

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Regulatory Changes – Georgia



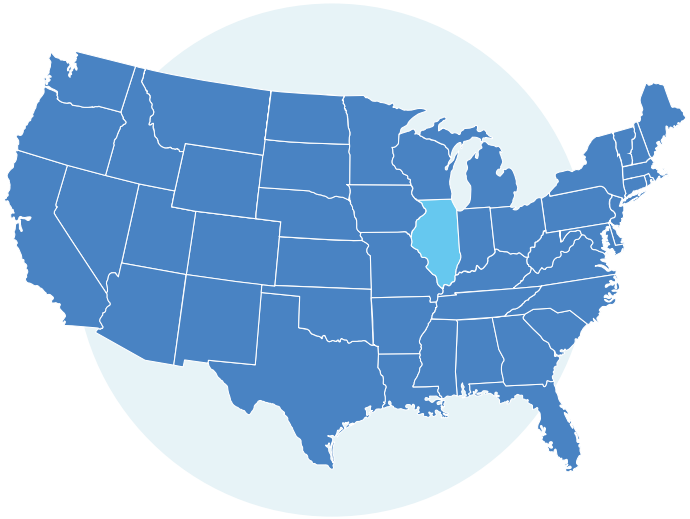
AI, UR, RX

S.B. 444: Applicable to fully insured Georgia health plans and TPAs and PBMs that administer those plans

- AI systems, AI, and other software tools may be used to automate tasks, reduce administrative burdens, participate in decision-making processes, and perform other lawful functions; provided, however, that such systems do not issue denials to a patient until a natural person qualifying as a PRA/UR entity conducts a UR in which a clinical peer participates. In no event should AI systems, AI, and other software tools supersede the judgment of a clinical peer

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Regulatory Changes – Illinois



RX, Prior Auth, Criteria

S.B. 1238: Applicable to fully insured IL health plans and TPAs and PBMs that administer those plans

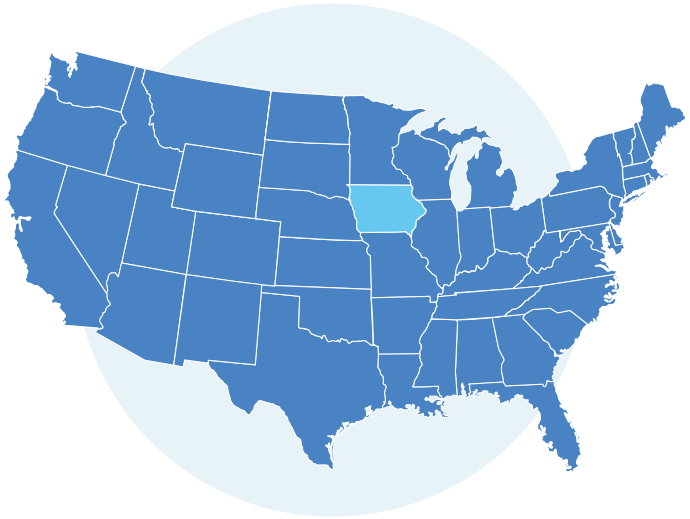
- Plans must provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, nonopioid, nonnarcotic pain management services and non medication pain management services that serve as alternatives to the prescribing of opioid or narcotic drugs in accordance with guidelines developed by DOI.

S.B. 238: Applicable to Medicaid

- Requires the Commissioner to review the Department's prior authorization and utilization management requirements and recommend adaptations for the Medicaid population

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Regulatory Changes – Iowa*



Prior Auth, UR, AI, Specialty Match, Reviewer Qualifications, RX

H.B. 2635: Applicable to fully insured IA health plans and TPAs and PBMs that administer those plans

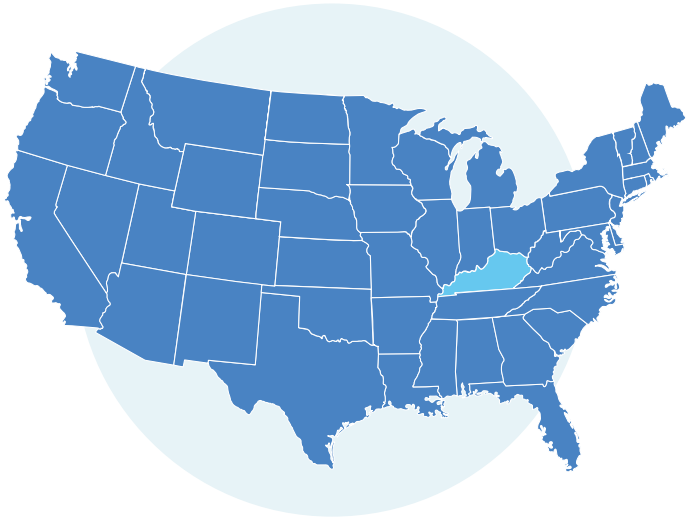
- UROs may not use AI as the sole basis for denying, delaying, or downgrading prior authorization requests based on medical necessity.
- Electronic PA process must be in effect by 7/1/2027
- All PA denials must be reviewed by same/similar specialty reviewer who has the training and expertise to treat the specific medical condition that is the subject of a request for prior authorization, including sufficient knowledge to determine whether the health care service that is the subject of the request is medically necessary or clinically appropriate.
- Requires that there be no additional PA/UR requirements for:
    - Cancer screenings if recommend based on the latest national guidelines.
    - Emergency care during a hospital stay

* Part goes into effect 1/1/2027 and the rest on 7/1/2027

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Regulatory Changes – Kentucky*



UR, Prior Auth, Gold Card

H.B. 176, S.B. 97: Applicable to fully insured health plans and TPAs and PBMs that administer those plans

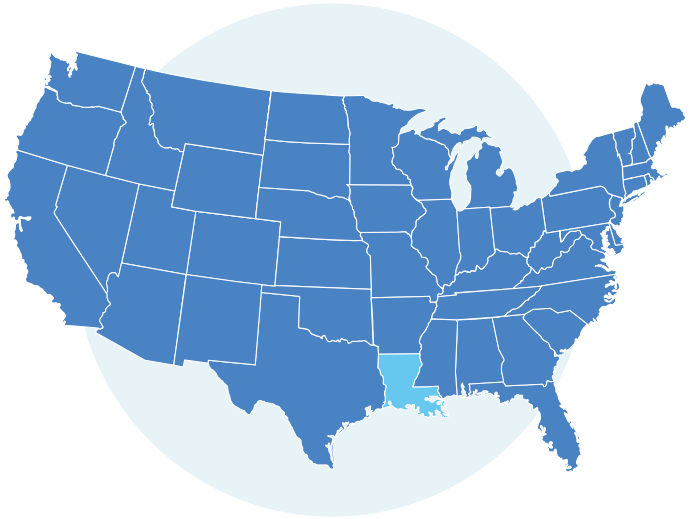
- Providers or provider groups with a 93% approval rate of PA requests for a health care service shall receive a PA exemption for that health care service. Evaluation period is annual, and evaluation must occur on the contract renewal date or the anniversary of the contract date for contracts that renew less frequently than annually.
- Requires that all health benefit plans provide coverage for prostheses and orthoses that meets or exceeds Medicare standards and includes coverage for multiple devices per affected limb, materials, instruction, repairs, and replacements under specified conditions.
- Insurers must ensure UR decisions are made in a nondiscriminatory manner and not deny coverage solely based on the patient's actual or perceived disability.

* Part goes into effect 1/1/2027 and the rest on 1/1/2028

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Regulatory Changes – Louisiana*



RX, Prior Auth

H.B. 1154: Applicable to fully insured health plans

Requires that there is no PA requirement for the dispensing/reimbursement of a generic medication that is not an opioid, if the prescription for the medication is issued by a board-certified physician.

H.B. 295: Applicable to fully insured health plans

Adverse determinations must be made by clinical peer reviewers. Requires coverage for medically necessary treatment related to acquired brain injuries without lifetime limitations or unreasonable annual limitations.

H.B. 909: Applicable to fully insured health plans

Requires coverage for mobile crisis response and behavioral health crisis care services provided by eligible provider w/o PA. Eff 7/1/2027

H.B. 1235: Applicable to fully insured health plans and Medicaid

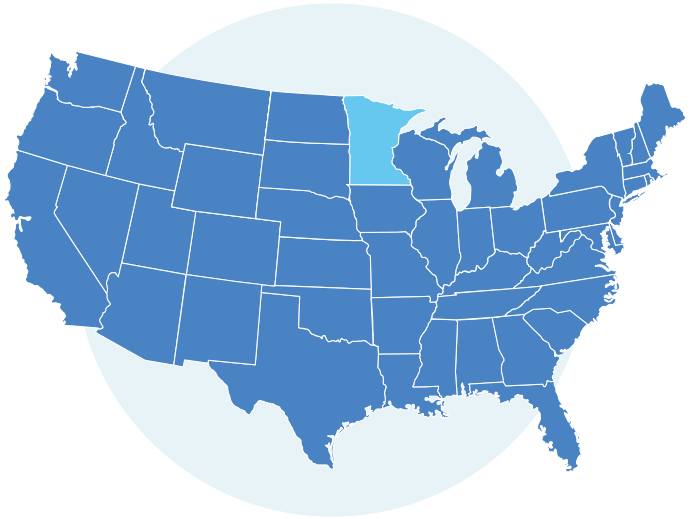
Requires coverage for prosthetic and orthotic devices and services when determined medically necessary, with coverage meeting at least the prevailing Medicare payment rate. Plans must provide coverage for additional upper or lower extremity prosthetic or orthotic devices when medically necessary for physical activities, bathing, or showering.

* Part goes into effect 1/1/2027 and the rest on 7/1/2027

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Regulatory Changes – Minnesota



RX, AI, UR

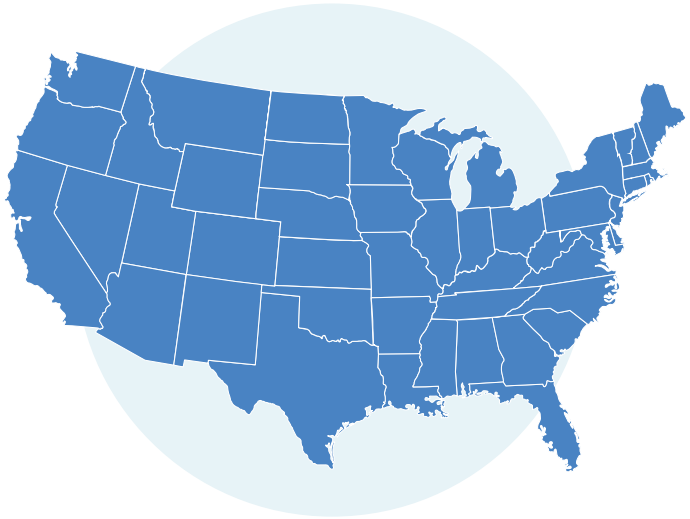
H.B. 4188: Applicable to fully insured MN health plans and TPAs and PBMs that administer those plans

- A URO is prohibited from using an algorithm or AI alone without a clinician review by an appropriate health professional when making an adverse determination.

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Regulatory Changes – New Hampshire



RX, Prior Auth, Step Therapy

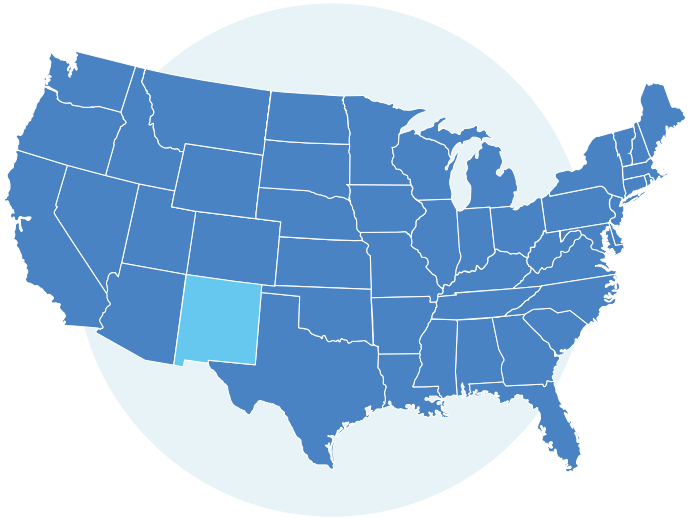
H.B. 241: Applicable to fully insured health plans

- Health carriers must develop comprehensive pain management programs that provide access to a broad spectrum of covered services including non-medication and non-opioid treatment options.
- These program must establish utilization controls, including PA or ST requirements, for clinically appropriate non-opioid drugs approved by the US FDA for the treatment or management of pain, that are not more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

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Regulatory Changes – New Mexico



RX, Prior Auth

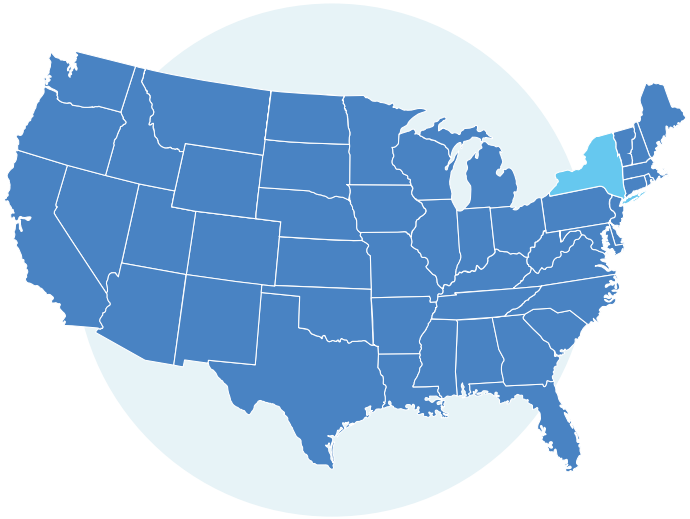
S.B. 20: Applicable to fully insured NM health plans and TPAs and PBMs that administer those plans

- Prohibits PAs for certain prescription drugs prescribed to treat serious mental illness; limits PAs for drugs that treat chronic health conditions.

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Regulatory Changes – New York



RX, Prior Auth, UR

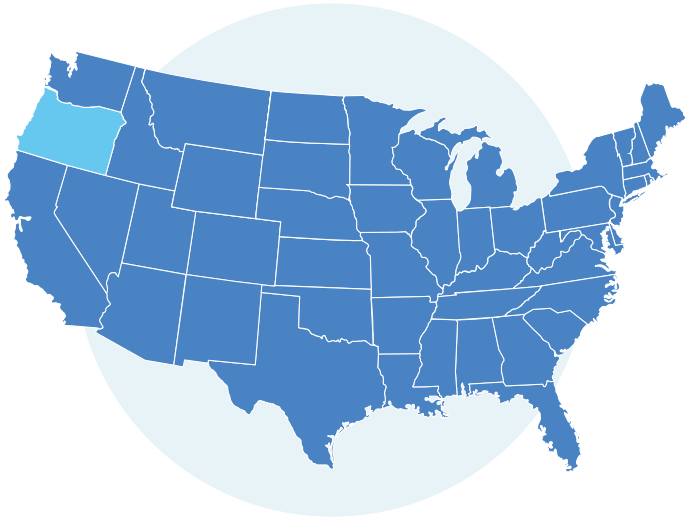
A.B. 10008: Applicable to fully insured NY health plans and TPAs and PBMs that administer those plans

- Requires health insurance companies and health plans to provide annual reporting on PAs, complaints and appeals.

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Regulatory Changes – Oregon



Prior Auth

H.B. 3134: Applicable to fully insured OR health plans

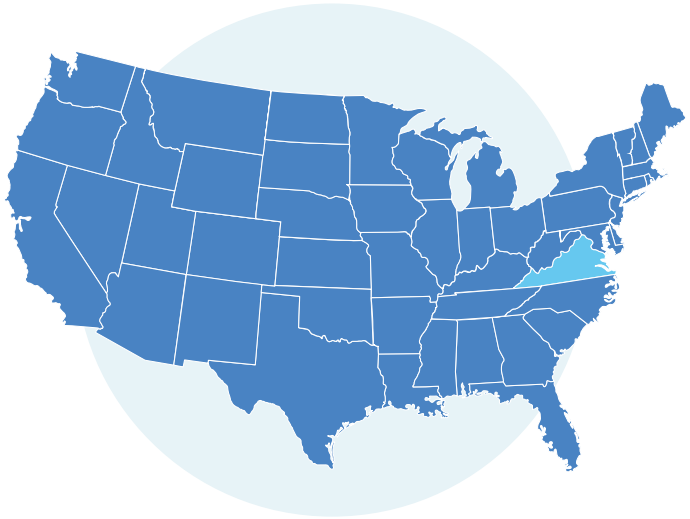
Requires that an insurer offering a health benefit plan that requires PA for surgical procedures may not require PAs for an additional/related health care procedure that is identified during the authorized surgical procedure if:

- The provider, while providing an approved surgical procedure, identifies a medical condition, disease or ailment that was not identified in the PA request and, in accordance with generally accepted standards of medical practice, determines that performing a related health care procedure, instead of or in addition to the approved surgical procedure, is medically necessary and, in the provider's judgment, to interrupt or delay the care in order to obtain prior authorization for the additional or related health care procedure would not be medically advisable;
- The additional or related health care procedure is a covered benefit under the enrollee's health benefit plan; and
- The additional or related health care procedure is not experimental or for investigation purposes.

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Regulatory Changes – Virginia



RX, Prior Auth, UR, Reviewer Qualifications, Notice Information

H.B. 481: Applicable to fully insured VA health plans

- Requires all prior auth adverse determinations for health care/pharmacy services are made by a licensed physician or, if a licensed physician is not available, a licensed pharmacist.

S.B. 701: Applicable to fully insured VA health plans and HMOs

All adverse determinations must include a unique identifier and business address and telephone number of the medical director/associate medical director who made the determination or the designated employee/representative of the plan who has responsibility for the plan's internal appeal process. Standard TAT: 5 business days

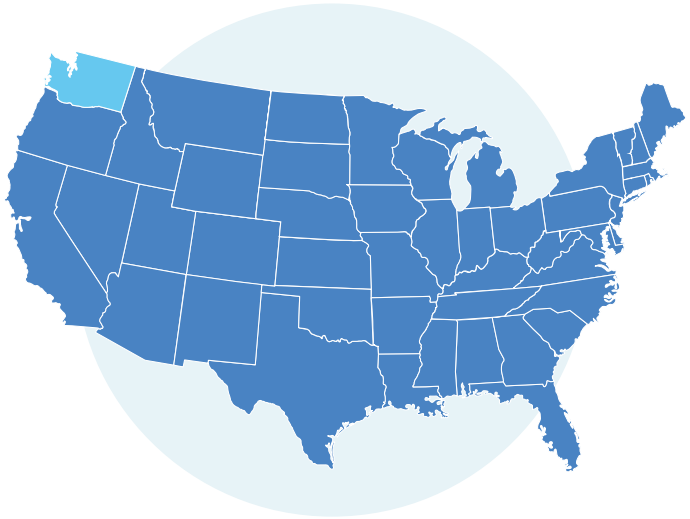
S.B. 172: Applicable to fully insured VA health plans and HMOs

Adds requirement that a provider may submit and the carrier must accept electronic documentation. No carrier will require submission of such documentation by paper, facsimile, or other non-electronic means if an electronic attachment can be used.

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Regulatory Changes – Washington



RX, Prior Auth

H.B. 1881: Applicable to fully insured health plans and TPAs and PBMs that administer those plans

- **Pharmacy Adverse Determinations** – must include alternative prescription drugs covered by the plan's formulary and made by a physician, pharmacist, or licensed mental health professional with training, knowledge, or expertise to apply appropriate clinical guidelines to the service being requested, and under the direction of a medical director
- **Appeals** – Require specialty matched physician, pharmacist, or mental health professional with experience treating the condition and complications
- **Timelines** – Pharmacy prior auth reviews due in 4 business days (standard) or 24 hrs. (urgent)
- **Validity** – Prior auths for chronic conditions shall be valid for 3 years unless criteria changes, the drug is removed from the formulary or moved to a less preferred tier on the formulary.

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