# Ohio Legislative Service Commission

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# Fiscal Note & Local Impact Statement

**Bill**: S.B. 129 of the 131st G.A. **Date**: December 16, 2015

**Status**: As Passed by the Senate **Sponsor**: Sens. Gardner and Cafaro

**Local Impact Statement Procedure Required**: Yes

**Contents**: Related to the prior authorization requirements of insurers

## State Fiscal Highlights

- The bill may minimally increase the Department of Insurance's administrative costs related to prior authorization requirements. Any such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill allows the Superintendent of Insurance to impose fines and penalties related to violations associated with prior authorization requirements. Any fines and penalties collected would also be deposited into Fund 5540.
- The bill would increase administrative costs to the state health benefit plan related to prior authorization requirements. There may be an increase in benefit costs related to some of the specific requirements of the bill, and the cost increases could be significant, though LSC staff are uncertain about this. Any increase in costs to the state plan would be paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds.
- The bill would likely increase Medicaid managed care organizations', and subsequently the Ohio Department of Medicaid's (ODM), administrative costs related to prior authorization requirements. The amount of the increase is unknown.

## Local Fiscal Highlights

- The bill would increase administrative costs to local governments' health benefit plans related to prior authorization requirements. There may also be increases in benefit costs due to some of the specific requirements of the bill, and the cost increases could be significant, though LSC staff are uncertain about this.

# Detailed Fiscal Analysis

## Health insurance

The bill specifies that health insurers that require a prior authorization must comply with prior authorization requirements as specified under this bill. The bill defines a "prior authorization requirement" as any practice implemented by an insurer in which coverage of a health care service, device, or drug is dependent upon a covered person or a health care practitioner obtaining approval from the insurer prior to the service, device, or drug being performed, received, or prescribed, as applicable. The bill specifies that "prior authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug. Under the bill, the term "health insurers" applies to health insuring corporations, sickness and accident insurers, public employee benefit plans, and multiple employer welfare arrangements.

The bill lays out 12 requirements that must be met by any prior authorization program. The requirements generally lay out administrative procedures which would largely affect administrative costs for health insurers, and would likely produce minimal if any increase in premiums to compensate for the costs, and thus would likely have no fiscal effect on governments as employers. However there are potentially significant fiscal effects from at least some of the criteria, such as: (1) the fourth criterion, which requires insurers to respond to all prior authorization requests within one business day for urgent care services, and five business days for nonurgent care services,[1] and requires the insurers to indicate whether the request is approved, denied, or incomplete, before time expires,[2] (2) the sixth criterion, which, in relation to a prior approval related to a chronic condition,[3] requires an insurer to honor a prior authorization approval for an approved drug that meets certain conditions under the bill, (3) the ninth criterion, which requires insurers to permit a retrospective review for a claim that is submitted for a service that meets certain requirements where prior authorization was required but not obtained, and (4) the twelfth criterion, which requires insurers to establish a streamlined reconsideration and appeal process related to adverse prior authorization decision determinations.

[1] In each case, the time limit is measured from the time the request, including all information necessary to support the prior authorization, is received by the insurer.

[2] If the request is denied or incomplete, the insurer must provide the specific reason for the denial or indicate the specific additional information that is required to process the request, respectively.

[3] The bill provides a definition of a "chronic condition."

Under the bill, beginning January 1, 2017, prior authorization determinations related to benefit coverage and medical necessity will be binding on the insurer if obtained not more than 60 days prior to the date the service, drug, or device is provided or received, except in cases of fraudulent or materially incorrect information. The bill also specifies that an insurer is not required to cover such service, drug, or device if the covered individual switches health plans. The bill provides that beginning January 1, 2017, an insurer may not impose a restriction or condition in relation to prior authorization determinations that limits, restricts, or effectively eliminates the binding force of the determinations that is established under this bill. The bill specifies that beginning January 1, 2017, if an insurer fails to comply with the prior authorization requirements it is considered to have committed an unfair and deceptive practice under existing law.

### Fiscal effect

The bill may minimally increase the Department of Insurance's administrative costs related to regulating prior authorization requirements. Any such increase would be paid from the Department of Insurance Operating Fund (Fund 5540). The Superintendent of Insurance may also impose fines and penalties for committing unfair or deceptive acts in the business of insurance under existing law. Any fines and penalties collected for violations related to prior authorization requirements would also be deposited into Fund 5540, thereby helping to offset any increase in such costs.

Because the bill imposes requirements on health insurers, and public employee benefit plans in particular, it has the potential to increase costs for the state and for local governments to provide health benefits to workers and their dependents.

However, LSC economists could not determine the magnitude of the fiscal impact associated with prior authorization requirements. Currently, the state administers a self-insured health benefits plan in which the state pays all benefit costs directly while contracting with private insurers to administer the benefits. Any increase in costs to the state plan would be paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds.

The prior authorization requirements under the bill may increase administrative and benefit costs for local governments' health benefit plans. However, LSC staff are unable to quantify the bill's fiscal impact on local governments due to lack of information on the details related to local governments' health benefit plans' prior authorization requirements.

## Medicaid

The bill specifies that if a medical assistance program (i.e., Medicaid) has a prior authorization requirement, ODM or its designee are to follow a number of requirements, including: permitting a health care provider, on or before January 1, 2018, to access the prior authorization form through the applicable electronic software system; permitting ODM or its designee, on or before January 1, 2018, to accept and respond to prior prescription benefit authorization requests through a secure electronic transmission (facsimile or a proprietary payer portal that does not use NCPDP SCRIPT standard are not considered a secure electronic transmission); allowing a health care provider and ODM or its designee, on or before January 1, 2018, to enter into a contractual arrangement to process prior authorization requests that are not submitted electronically; requiring ODM or its designee, on or before January 1, 2018, to respond to all prior authorization requests within one business day for an urgent care service, or five business days for any prior approval request that is not for an urgent care service; requiring ODM or its designee, on or before January 1, 2018, to provide a written receipt to the health care provider acknowledging that the prior authorization request was received; requiring ODM or its designee, on or before January 1, 2017, to honor a prior authorization approval for an approved drug for the lesser of, from the date of approval, 12 months, or the last day of the medical assistance recipient's eligibility for the medical assistance program; allowing ODM or its designee, on or before January 1, 2017, to provide 12-month approval for certain drugs; requiring ODM or its designee, on or after January 1, 2017, to permit a retroactive review for a claim that was submitted for a service where prior authorization was required but not obtained; requiring ODM or its designee, on or before January 1, 2017, to disclose to all participating health care providers any new prior authorization requirement at least 30 days prior to the effective date of the new requirement; requiring ODM or its designee, on or before January 1, 2018, to establish a streamlined reconsideration and appeal process relating to adverse prior authorization determinations; and requiring ODM or its designee to make available on ODM's website or provider portal, on or before January 1, 2017, a listing of its prior authorization requirements.

### Fiscal effect

The bill would likely increase Medicaid managed care organizations', and subsequently ODM's, administrative costs related to prior authorization requirements. The amount of this increase is unknown. This could also include some information technology (IT) costs due to the bill's provision regarding secure electronic transmission of prior authorization forms.