Ohio Legislative Service Commission

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Fiscal Note & Local Impact Statement

Bill: S.B. 129 of the 131st G.A.

Date: November 10, 2015

Status: As Introduced

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 or drug is dependent upon a covered person, or a health care provider, notifying the insurer or plan that the service or drug is going to be provided or requesting or receiving approval from the insurer. The bill specifies that "prior authorization" includes any precertification, notification, or referral program, or a prospective or utilization review conducted prior to providing a health care service 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 first requirement is to employ a prior authorization form adopted by the Superintendent of Insurance. The other 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 three of the criteria: (1) the fifth criterion, which requires insurers to respond to all prior authorization requests within 24 hours for urgent medical needs, and 48 hours for all other medical needs,[1] and requires automatic approval of the request if time expires, (2) the seventh criterion, which prohibits an insurer from retroactively denying coverage for an approved medical service or drug, and (3) the twelfth criterion, which requires insurers to establish an appeal process.

The bill requires the Superintendent of Insurance to adopt, by rule, a standard form to be used for prior authorization requests. The bill also specifies that the rule and the standard form must include criteria for determining when a prior authorization request involves an urgent medical need. The bill specifies that 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

[1] In each case, the time limit is measured from the time the request is received by the insurer.

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. LSC economists are uncertain whether the three requirements singled out above would significantly increase insurers' benefit costs. It is not clear, for example, how feasible the 48-hour limit for approval of nonemergency procedures would be for insurers to meet, especially when the bill does not include an accommodation for weekend hours. Similarly, the prohibition against retroactive denials appears to be absolute and thus not to make an allowance for fraudulent requests. There seems to be, therefore, a possibility of significant increases in insurance premiums and other health benefit payments.

The bill may therefore increase administrative and benefit costs to the state health benefit plan 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 requires the Ohio Department of Medicaid (ODM) to establish a standardized form to be used by Medicaid recipients, and individuals acting on behalf of such individuals, to request prior authorization for health care services and items that require prior authorization. ODM may provide for the form to be completed and submitted to ODM or its designee, including Medicaid managed care organizations, through an electronic submission process. To the extent possible, the form is to be modeled on the standardized prior authorization form adopted by the Superintendent of Insurance.

The bill specifies that if a Medicaid assistance program has a prior authorization requirement, ODM or its designee are to follow a number of requirements. Some of which include: permitting health care providers to, one year after the effective date of the bill, access the prior authorization form through the provider's electronic software system; permitting ODM or its designee to accept, one year after the effective date of the bill, prior authorization forms through secure electronic transmission (facsimile is not

considered a secure electronic transmission); responding to all prior authorization requests within 24 hours for urgent health care needs and 48 hours for other health care needs and requires automatic approval if the deadline is not met; prohibiting retroactive denial of coverage for the approved health care service or item; ensuring that an adverse prior authorization decision be made by a physician or nurse under the direction of ODM or its designee or a panel of appropriate health care reviewers; and making available on ODM's website certain information such as the most recently published drug formulary, the drug utilization management system for each prescribed drug placed on the formulary, and cost-sharing requirements that apply to the program.

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.

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