Ohio Legislative Service Commission

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Fiscal Note & Local Impact Statement

Bill: S.B. 129 of the 131st G.A. **Date**: May 24, 2016

Status: As Reported by House Insurance **Sponsor**: Sens. Gardner and Cafaro

Local Impact Statement Procedure Required: Yes

Contents: Related to the prior authorization requirements of insurers and to delay the effective date of certain laws regarding community mental health and addiction services

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 specifies that the requirements related to prior authorization do not apply to certain types of coverage. Those exceptions are detailed in the bill and LSC's Bill Analysis.

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.

Under the bill, beginning January 1, 2017, except in cases of fraudulent or materially incorrect information, the bill prohibits insurers from retroactively denying a prior authorization for a health care service, drug, or device when all of the conditions specified under the bill are met. The bill specifies that any provision of a contractual arrangement entered into between an insurer and a health care practitioner or beneficiary that is contrary to the provisions in this bill is unenforceable. The bill also states that beginning January 1, 2017, if an insurer issues policies committing a series of violations related to this bill that, taken together, constitute a practice or pattern, the insurer would be considered to have committed an unfair and deceptive practice under existing law. The bill provides that the Superintendent of Insurance may adopt rules as necessary to implement prior authorization provisions in the bill.

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 for prescription drug requests 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 approve or deny all prior authorization requests within 48 hours for an urgent care service, or 10 calendar 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 an electronic 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 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 appeal process relating to adverse prior authorization determinations.

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.

Community mental health and addiction services–delayed effective dates

The bill delays the implementation of the continuum of care requirements in Am. Sub. H.B. 483 of the 130th General Assembly, as modified by Am. Sub. H.B. 64 of the 131st General Assembly, from September 15, 2016 to July 1, 2017. This includes a provision that specifies that the Ohio Department of Mental Health and Addiction Services must withhold funds from an alcohol, drug addiction, and mental health services board unable to provide all of the services in the continuum of care.

Fiscal effect

The fiscal effects of the previously enacted legislation will be delayed until July 1, 2017.

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