LEGISLATIVE SERVICES AGENCY
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FISCAL IMPACT STATEMENT

LS 6843
BILL NUMBER: SB 3

NOTE PREPARED: Jan 4, 2024
BILL AMENDED:

SUBJECT: Prior Authorization.

FIRST AUTHOR: Sen. Johnson T
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
X **DEDICATED**
X **FEDERAL**

IMPACT: State & Local

Summary of Legislation: *Annual Utilization Reviews:* The bill provides that a utilization review entity may only impose prior authorization requirements on less than 1% of any given specialty or health care service and 1% of health care providers overall in a calendar year.

Prohibited Utilization Review Subjects: The bill prohibits a utilization review entity from requiring prior authorization for:

(1) a health care service that is part of the usual and customary standard of care;
(2) a prescription drug that is approved by the federal Food and Drug Administration;
(3) medication for opioid use disorder;
(4) pre-hospital transportation; or
(5) the provision of an emergency health care service.

Utilization Review Requirements and Appeals: The bill sets forth requirements for a utilization review entity that requires prior authorization of a health care service. It provides that all adverse determinations and appeals must be reviewed by a physician who meets certain conditions.

Health Care Provider Exemptions: The bill requires a utilization review entity to provide an exemption from prior authorization requirements if in the most recent 12 month period the utilization review entity has approved or would have approved at least 80% of the prior authorization requests submitted by the health care provider for a particular health care service.

The bill repeals superseded provisions regarding prior authorization, and it makes corresponding changes.

Effective Date: July 1, 2024.

Explanation of State Expenditures: If utilization increases as a result of the limitations on prior authorization (PA) and utilization management provisions of the bill, additional claims may be paid. Additional claims payment may result in an increase in health care premiums for the state employees health plans (SEHP) or capitation rates paid to the health plans that provide the state's Medicaid risk-based care. The bill's provisions for revoking a provider PA exemption may mitigate some of additional cost of services.

Additionally, the bill changes the responsibility for PA from a health plan to a utilization review entity. It shortens the time frames for PA decisions and specifies who may make PA decisions and hear appeals. As a result, the cost of administering a PA program may increase. However, the overall cost increase is indeterminate and the impact may be offset by a decrease in the number of claims that may be reviewed.

A physician that makes an adverse determination or reviews an appeal owes a duty to the covered individual. A violation of this standard could be subject to medical malpractice with a judgment payable by the Indiana Patients Compensation Fund.

Additional Information - PA can limit the type, location, or number of services provided by denial of authority to treat or with abandonment of care by the patient. The bill potentially reduces the number of prior authorizations required by removing certain reasons to deny services and removing limits on PA.

The bill's provision for a 1% limit on review of claims or providers reviewed annually may not have an impact on the SEHP. For the two-year period ending July 31,2022, 1% of claims were subject to utilization review. MRI/CAT scan, durable medical equipment rental, surgical, diagnostic medical, and pain management were the most frequently reviewed categories of services.

An increase in premiums cost for the SEHP may be mitigated with adjustments to other benefits or to employee compensation packages, or through the division of premium costs between the state and its employees. Medicaid and the Children's Health Insurance Program (CHIP) are jointly funded between the state and federal governments. The state share of costs for most Medicaid medical services for FFY 2024 is 34%, 10% for the age 19 to 64 expansion population within the Healthy Indiana Plan (HIP), and 24% for CHIP. The state share of most Medicaid and CHIP expenditures is paid from state General Fund appropriations, and state dedicated funds primarily cover HIP costs.

Explanation of State Revenues: A utilization increase may result in an increase in health care premiums. If overall premiums collected in the state increase, revenue to the state General Fund could increase from either corporate Adjusted Gross Income Tax or Insurance Premium Tax collections.

Health care service PA requirements are subject to the unfair and deceptive business practices in insurance penalties. The penalty for engaging in an unfair and deceptive act is a civil penalty between $25,000 and $50,000 for each act or violation. The revocation of a insurers license or certificate of authority for knowingly engaged in an unfair or deceptive act would result in a reduction in fee revenue to the DOI agency fund.

Explanation of Local Expenditures:. An increase in claims and premiums cost for local units providing health care coverage may be mitigated with adjustments to other benefits or to employee compensation packages, or through the division of premium costs between a local unit and its employees.

Explanation of Local Revenues:

State Agencies Affected: All.

Local Agencies Affected: Local units providing health insurance.

Information Sources: Christy Tittle, State Personnel Department.

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