COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

**FISCAL NOTE**

L.R. No.: 1735-01
Bill No.: HB 751
Subject: Insurance - Health
Type: Original
Date: March 7, 2019

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Bill Summary: This proposal enacts provisions relating to payments for health care services.

## FISCAL SUMMARY

| ESTIMATED NET EFFECT ON GENERAL REVENUE FUND | | | |
|---|---|---|---|
| FUND AFFECTED | FY 2020 | FY 2021 | FY 2022 |
| General Revenue Fund | Could exceed ($3,840,280) | Could exceed ($3,840,280) | Could exceed ($3,840,280) |
| **Total Estimated Net Effect on General Revenue** | **Could exceed ($3,840,280)** | **Could exceed ($3,840,280)** | **Could exceed ($3,840,280)** |

| ESTIMATED NET EFFECT ON OTHER STATE FUNDS | | | |
|---|---|---|---|
| FUND AFFECTED | FY 2020 | FY 2021 | FY 2022 |
| Other Funds | Could exceed ($907,060) | Could exceed ($907,060) | Could exceed ($907,060) |
| Insurance Dedicated Fund (0566) | $59,550 | $0 | $0 |
| **Total Estimated Net Effect on Other State Funds** | **Could exceed ($847,510)** | **Could exceed ($907,060)** | **Could exceed ($907,060)** |

Numbers within parentheses: ( ) indicate costs or losses. This fiscal note contains 10 pages.

| ESTIMATED NET EFFECT ON FEDERAL FUNDS | | | |
|---|---|---|---|
| FUND AFFECTED | FY 2020 | FY 2021 | FY 2022 |
| Federal Funds | Could exceed ($1,452,660) | Could exceed ($1,452,660) | Could exceed ($1,452,660) |
| | | | |
| **Total Estimated Net Effect on All Federal Funds** | **Could exceed ($1,452,660)** | **Could exceed ($1,452,660)** | **Could exceed ($1,452,660)** |

| ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE) | | | |
|---|---|---|---|
| FUND AFFECTED | FY 2020 | FY 2021 | FY 2022 |
| | | | |
| | | | |
| **Total Estimated Net Effect on FTE** | **0** | **0** | **0** |

☒ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $100,000 in any of the three fiscal years after implementation of the act.

| ESTIMATED NET EFFECT ON LOCAL FUNDS | | | |
|---|---|---|---|
| FUND AFFECTED | FY 2020 | FY 2021 | FY 2022 |
| **Local Government** | **$0** | **$0** | **$0** |

## FISCAL ANALYSIS

ASSUMPTION

Section 376.1350

Officials form the **Missouri Consolidated Health Care Plan (MCHCP)** assume this proposal enacts provisions relating to payments for health care services.

MCHCP consulted with its contracted third party administrators (TPA) and pharmacy benefit manager (PBM) to provide input on the financial impact of this proposed legislation.

The language in this proposed legislation adds a definition of prior authorization to be an affirmative determination of coverage made pursuant to a prior authorization review. MCHCP's definition of preauthorization is "A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. . . . . Preauthorization is not a promise the plan will cover the cost. . . . " The proposed language significantly expands the prior authorization definition from a review of medical necessity to a determination of coverage which expands the scope of the review to include not only a review of medical necessity to include a claim processing review. The provider will have to provide a proposed claim in addition to any clinical data to clear the potential claim for payment. Claims processing include, in summary, an automated review of edits that check for issues such as member status, provider status, benefit accumulators, correct coding edits to detect potential fraud and abuse, and other issues. This significant additional scope of review will add time to the review for medical necessity. In addition the definition of certification includes a requirement that a determination by a health carrier or a utilization review entity will include a determination that payment will be made for that health care service. Similar to the prior authorization, that expands the scope of the certification process to include a claims processing component to determine claims payment. The provider will have to provide additional billing information for that determination to be complete. Any deviation the provider makes to the final bill after services are complete, could result in a change to the payment determination.

The proposed language also changes the MCHCP's definition of medical necessity which reads in current regulation, "Medically necessary". The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its designee determines, in the exercise of its discretion are— (A) Expected to be of clear clinical benefit to the member; (B) Clinically appropriate, in terms of

ASSUMPTION (continued)

type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms; C) In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community; (D) Not primarily for member or provider convenience; and (E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms." The proposed language provides the review for medically necessary is that of what a prudent health care provision would provide. Absent a definition of prudent health care professional, MCHCP is assuming all licensed health care professionals would be considered a prudent health care professional.

Additionally, the proposed legislation has many provisions that will impact the scope and extent of services that a PBM can conduct for plan sponsors, specifically the proposed language relating to step therapy protocols and prior authorizations.

The fiscal impact of this proposed legislation is unknown but greater than $6.2 million based on historical medical and pharmacy claim payments associated with current prior authorization and step therapy protocols.

**Oversight** notes that the MCHCP has stated the proposal would have an unknown but greater than $6.2 million cost. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a cost of "Could exceed" $3,840,280 to the General Revenue Fund, $907,060 to Other Funds and $1,452,660 to Federal Funds based on the following MCHCP fund splits provided by the Office of Administration

| | |
|---|---|
| General Revenue | 61.94%; |
| Federal | 23.43%; and |
| Other | 14.63% |

*Sections 374.500 - 376.1387*

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** estimates 397 companies will file one policy amendments each for a total of 397 filings submitted to the department for review along with a $150 filing fee. Additional revenues to the Insurance Dedicated Fund are estimated to be up to $59,550 (397*150=$59,550).

ASSUMPTION (continued)

Additional staff and expenses are not being requested with this single proposal, but if multiple proposals pass during the legislative session which require policy form reviews the department may need to request additional staff to handle increase in workload.

**Oversight** notes that the DIFP has stated the proposal would not have a direct fiscal impact on their organization. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a revenue to the Insurance Dedicated Fund of $59,550 in FY 2020 and no additional cost to DIFP on the fiscal note.

Officials from the **Department of Social Services**, the **Department of Health and Senior Services**, the **Department of Mental Health**, the **Missouri Department of Conservation**, the **Department of Transportation** and the **Department of Public Safety** - **Missouri Highway Patrol** each assume the proposal will have no fiscal impact on their respective organizations.

**Oversight** notes that the above mentioned agencies have stated the proposal would not have a direct fiscal impact on their organization. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact on the fiscal note.

Officials from the **Office of Administration** defer to the Missouri Consolidated Health Care Plan to estimate the fiscal impact of the proposed legislation on their respective organization.

| FISCAL IMPACT - State Government | FY 2020 (10 Mo.) | FY 2021 | FY 2022 |
|---|---|---|---|
| **GENERAL REVENUE FUND** | | | |
| Cost - MCHCP | Could exceed | Could exceed | Could exceed |
| Prior authorization and step therapy protocols | ($3,840,280) | ($3,840,280) | ($3,840,280) |
| **ESTIMATED NET EFFECT TO THE GENERAL REVENUE FUND** | **Could exceed ($3,840,280)** | **Could exceed ($3,840,280)** | **Could exceed ($3,840,280)** |

| FISCAL IMPACT - State Government (continued) | FY 2020 (10 Mo.) | FY 2021 | FY 2022 |
|---|---|---|---|
| **OTHER FUNDS** | | | |
| Cost - MCHCP<br>Prior authorization and step therapy protocols | Could exceed ($907,060) | Could exceed ($907,060) | Could exceed ($907,060) |
| **ESTIMATED NET EFFECT ON OTHER FUNDS** | **Could exceed ($907,060)** | **Could exceed ($907,060)** | **Could exceed ($907,060)** |
| **FEDERAL FUNDS** | | | |
| Cost - MCHCP<br>Prior authorization and step therapy protocols | Could exceed ($1,452,660) | Could exceed ($1,452,660) | Could exceed ($1,452,660) |
| **ESTIMATED NET EFFECT ON FEDERAL FUNDS** | **Could exceed ($1,452,660)** | **Could exceed (1,452,660)** | **Could exceed ($1,452,660)** |
| **INSURANCE DEDICATED FUND** | | | |
| Revenue - DIFP<br>$150 filing fee | $59,550 | $0 | $0 |
| **ESTIMATED NET EFFECT TO THE INSURANCE DEDICATED FUND** | **$59,550** | **$0** | **$0** |

| FISCAL IMPACT - Local Government | FY 2020 (10 Mo.) | FY 2021 | FY 2022 |
|---|---|---|---|
| | **$0** | **$0** | **$0** |

FISCAL IMPACT - Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

FISCAL DESCRIPTION

This act enacts provisions relating to payments for health care services.
METHODS OF REIMBURSEMENT (Section 376.1345)

This act prohibits health carriers and entities acting on their behalf from restricting methods of reimbursement to a method requiring health care providers to pay a fee to redeem the amount of their claim for reimbursement.

Health carriers initiating a new method of reimbursement or changing the reimbursement method used shall notify in-network health care providers, and any other providers to whom the carrier has issued a prior authorization within the past year, whether any fee is required to receive reimbursement through the new or different method, and for health benefit plans issued, delivered, or renewed on or after August 28, 2019, shall allow the provider to select an alternative method of reimbursement which does not require a fee.

Violation of these provisions shall be deemed an unfair trade practice under the Unfair Trade Practice Act.

These provisions are similar to HB 492 (2019).

UTILIZATION REVIEWS (Sections 374.500, and 376.1350 to 376.1387)

This act replaces "utilization review organization" with "utilization review entity", and "prospective review" with "prior authorization review" throughout the statutes relating to utilization reviews.

This act adds health care services that are denied under a utilization review to the definition of "adverse determination", including with regard to the reconsideration process. The definition of "certification" is modified to refer to only those health care services approved for coverage which the health carrier or utilization review entity, as defined in the act, has also determined it will pay for. The definitions of "adverse determination" and "certification" are modified to refer to decisions made by "a utilization review entity" rather than a health carrier's "designee utilization review entity". "Clinical review criteria" is modified to include several specific policies and rules, as well as any other criteria or rationale used by a health carrier or utilization review entity

FISCAL DESCRIPTION (continued)

to determine appropriateness or necessity of health care services. "Health care service" is modified to specifically include the provision of drugs or durable medical equipment. (Section 376.1350)

This act prohibits health carriers and utilization review entities from requiring providers to follow a step therapy protocol, as defined in the act, when the provider determines the step therapy protocol is not in the enrollee's best interest. The act also prohibits carriers and review entities from requiring providers to obtain a waiver, exception, or other override when determining a step therapy protocol to not be in the enrollee's best interest. No carrier or review entity shall sanction or otherwise penalize any provider for recommending or performing a health care service that may conflict with a step therapy protocol. (Section 376.1362)

This act shortens the time period health carriers have to make initial decisions in a utilization review, from 36 hours to 24 hours. Under the act, providers shall be notified immediately upon the carrier making its initial and concurrent review decisions, instead of within 24 hours. This act repeals the requirement that written notice to enrollees of an adverse coverage determination include instructions for requesting a statement of the clinical rationale and review criteria used to make the determination. Written procedures to address a failure or inability of a provider or enrollee to provide all information necessary to make a decision shall be made available on the health carrier's website or provider portal. No utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider. The prior authorization shall be valid for one year from the date received unless revoked or restricted in writing in accordance with these provisions. Any failure by a utilization review entity to comply with these provisions shall be deemed authorization of the health care services being reviewed. (Section 376.1363.1-8)

For purposes of utilization reviews, a health care service shall be considered medically necessary if it is provided in a manner that is in accordance with generally accepted standards of health care practices; clinically appropriate in terms of the type, frequency, extent, and duration; and not primarily for the economic benefit of the health carrier, nor the convenience of the patient, treating physician, or other health care provider. (Section 376.1363.9)

No later than January 1, 2020, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 201310 or a backwards-compatible successor adopted by the United States Department of Health and Human Services. (Section 376.1364.1)

FISCAL DESCRIPTION (continued)

No later than January 1, 2020, the Department of Insurance, Financial Institutions, and Professional Registration shall develop a standard prior authorization form, which all health carriers shall use beginning January 1, 2021. (Section 376.1364)

The act requires health carriers and utilization review entities to make available on its web site any current prior authorization requirements or restrictions, including written clinical criteria. No health carrier or utilization review entity shall amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or review entity's website. Health carriers and utilization review entities shall provide in-network health care providers with written notice of the new or amended requirement not less than 60 days prior to implementing the requirement or restriction.

A carrier utilizing prior authorization review shall make statistics regarding approvals and denials available on its website in a readily accessible format, including categories for provider type or physician specialty, medication or diagnostic test or procedure, indication offered, and reason for denial. (Section 376.1372)

This act modifies the panel for a second-level grievance review for an adverse determination to require a majority of persons that are "actively practicing clinical peers licensed to practice medicine" rather than "appropriate clinical peers" in the same or similar specialty as would typically manage the case being reviewed. (Section 376.1385)

The act specifies that if an independent review organization reviews an adverse determination appeal and reverses the adverse determination, the health carrier shall reimburse the Department for any and all fees charged by the independent review organization. (Section 376.1387)

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Insurance, Financial Institutions and Professional Registration
Department of Social Services
Department of Health and Senior Services
Department of Mental Health
Missouri Consolidated Health Care Plan
Office of Administration
Missouri Department of Conservation
Department of Transportation
Department of Public Safety
Missouri Highway Patrol

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March 7, 2019

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March 7, 2019

KC:LR:OD