HB 19-1211

Legislative Council Staff

Nonpartisan Services for Colorado's Legislature

FISCAL NOTE

Drafting Number:	LLS 19-0894	**Date:**	March 11, 2019
Prime Sponsors:	Rep. Michaelson Jenet; Caraveo Sen. Williams A.	**Bill Status:**	House Health & Insurance
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Bill Topic: PRIOR AUTHORIZATION REQUIREMENTS HEALTH CARE SERVICE

Summary of Fiscal Impact:

- ☐ State Revenue
- ☒ State Expenditure *(minimal)*
- ☐ State Transfer
- ☐ TABOR Refund
- ☐ Local Government
- ☐ Statutory Public Entity

The bill establishes guidelines for the practice of prior authorization by heath insurance carriers. It will increase state expenditures on an ongoing basis.

Appropriation Summary: No appropriation is required.

Fiscal Note Status: The fiscal note reflects the introduced bill.

Summary of Legislation

Effective January 1, 2020, the bill establishes guidelines for health insurance carriers concerning the practice of prior authorization for medical procedures and drug benefits. The requirements do not apply to a nonprofit health maintenance organization (HMO) with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group. The Commissioner of Insurance may adopt rules to implement the bill.

Prior authorization. A health insurance carrier is required to post current prior authorization requirements on its website, including the requirements that apply if the carrier uses a private utilization review organization to review these claims. A carrier must post on its website data regarding approvals and denials of prior authorization requests. Prior authorization criteria must be based on current, clinically based criteria, and aligned with other quality initiatives and other carriers' and organizations' prior authorization criteria for the same health care services. A carrier must respond to prior authorization requests for medical procedures within time frames established by the bill; if a carrier fails to make a determination within that time, the request is deemed approved.

Carriers must limit the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from their peers, after adjusting for patient mix and other relevant factors. Carriers must exempt from prior authorization requirements any provider that has at least an 80 percent approval rate of prior authorization requests over the preceding 12 months. Any new prior authorization requirements implemented or changes to existing requirements require 90 days notice to any participating providers. Upon approval, a prior authorization request is valid for at least 180 days.

Background

Prior authorization is a process by which a health insurance carrier reviews a request for certain health care services or drugs before consenting to cover the proposed treatment. Upon receiving a request, a carrier can approve or deny the request, or request additional information. A carrier could employ this practice for a variety of reasons, including as a cost-control mechanism or to verify medical necessity.

State Expenditures

Beginning in FY 2019-20, the bill will impact workload and potentially expenditures for multiple state agencies.

Department of Regulatory Agencies. Health insurance carriers file health benefit plan information for review with the Division of Insurance in the Department of Regulatory Agencies. The division spends about 50 to 60 hours reviewing each filing. Incorporating a review of prior authorization practices to these filings will add an estimated 4 hours to each review. Given approximately 50 health benefit plans filing each year across the individual, small group, and large group markets, this will necessitate an annual workload increase of about 200 hours. This workload increase can be accomplished within existing appropriations.

Health Care Policy and Financing. Child Health Plan Plus (CHP+) plans are managed by HCPF and administered by multiple health insurance carriers. About 25 percent of claims are administered by plans that are exempt from the bill as HMOs. For the remaining plans subject to the bill, to the extent that the bill's restrictions on prior authorization requirements result in increased health care utilization, a corresponding increase in costs would follow. The fiscal note assumes that plans are not denying a significant number of claims through the prior authorization process, so no appreciable increase in utilization is expected. The department would account for any increase in rates through the annual budget process.

State employee insurance. One of the two state employee health plans is subject to the bill. Costs for this plan could increase if the restrictions on prior authorization result in increased health care utilization. There will be administrative costs associated with making prior authorization practices and data available to the public. Any cost increase could contribute to higher insurance premiums, which may increase costs for state agencies. Because state employee health insurance contributions are based upon prevailing market rates, with costs shared between the employer and employee, this bill is not expected to affect the state's share of employee health insurance premiums until FY 2020-21. Because insurance rates are influenced by a number of variables, the exact effect of this bill cannot be determined. Any increase caused by the bill will addressed through the total compensation analysis included in the annual budget process.

Effective Date

The bill takes effect August 2, 2019, if the General Assembly adjourns on May 3, 2019, as scheduled, and no referendum petition is filed. The bill applies to prior authorization requests for health care services submitted on or after January 1, 2020.

State and Local Government Contacts

Colorado Health Benefit Exchange
Regulatory Agencies
Personnel
Information Technology
Health Care Policy and Financing