Segal

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PURPOSE OF HB 1274

To modify the Prior Authorization Transparency Act; and to amend the appeal process for a denial under the Prior Authorization Transparency Act.

ACTUARIAL STATEMENT

The Fiscal Impact Statement was prepared according to generally accepted actuarial principles and practices, in compliance with ACT 112. The Statement provides an estimate of the financial and actuarial effect of the proposed change(s) on the Plans, if possible. The Statement makes no comment or opinion with regard to the merits of the measure for which the Statement is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness and relied upon the data and information provided by the Plans and their Claims Processing Contractors.

3/10/2023

Patrick Klein, FSA, MAAA
Vice President

Date

3/10/2023

Matthew Kersting, FSA, MAAA
Vice President

Date

PROJECTED COSTS

Plan	Annual Estimated Cost/(Savings)
EBD	No Material Impact
UOA	No Material Impact
ASU	No Material Impact
UCA	No Material Impact
AHEC	No Material Impact
NWACC	No Material Impact
SAU	No Material Impact

PRICING APPROACH AND COMMENTS

House Bill 1274 modifies the Prior Authorization Transparency Act and changes the process for appealing denials made for patients being treated for oncology, hematology, and other disease states or diagnoses chosen by the Arkansas Insurance Commissioner. A third-party administrator of a self-insured healthcare insurer is considered a utilization review entity if it performs prior authorizations.

If a nonurgent healthcare service is denied by a utilization review entity, either the subscriber or healthcare provider can appeal the adverse determination. After receiving all necessary information required, the utilization review entity must make a determination within four days and inform the subscriber and healthcare provider of the decision made.

If an urgent healthcare service is denied by a utilization review entity, either the subscriber or healthcare provider can appeal the adverse determination. After receiving all necessary information required, the utilization review entity must make a determination within two days and inform the subscriber and healthcare provider of the decision made.

Given the low expected incidence of appeals for patients being treated for oncology, hematology, and other disease states or diagnoses chosen by the Arkansas Insurance Commissioner, and the plans already offering an appeals process, this bill is expected to have no material impact to plan health costs. There could be an increase in administrative work placed on the third-party administrator, but we do not see this having an impact on plan cost.

Actual legislative cost impacts to health plans may vary as actual future experience differs from the assumptions made in developing these cost estimates. Potential for actual experience to vary from the assumptions made in these estimates including underlying changes to the cost of a health plan's administrative appeal process and changes in the incidence of appeals for the above specified disease states or diagnoses for each plan.