COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 6673H.01I
Bill No.: HB 3010
Subject: Health Care; Insurance - Health
Type: Original
Date: February 18, 2026

Bill Summary: This proposal creates provisions relating to prior authorization of health care services.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND

FUND AFFECTED	FY 2027	FY 2028	FY 2029
General Revenue	($844,500 to $1,356,500)	($832,000 to $1,344,000)	($832,000 to $1,344,000)
Total Estimated Net Effect on General Revenue	**($844,500 to $1,356,500)**	**($832,000 to $1,344,000)**	**($832,000 to $1,344,000)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Other State Funds	($195,000 to $315,000)	($195,000 to $315,000)	($195,000 to $315,000)
State Road Fund (1320)*	$0 or (Unknown)	$0 or (Unknown)	$0 or (Unknown)
Total Estimated Net Effect on Other State Funds	**(Unknown, Could exceed $195,000 to $315,000)**	**(Unknown, Could exceed $195,000 to $315,000)**	**(Unknown, Could exceed $195,000 to $315,000)**

*MoDOT assumes cost to be less than $250,000.
Numbers within parentheses: () indicate costs or losses.

ESTIMATED NET EFFECT ON FEDERAL FUNDS

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Federal Funds (MCHCP/DSS)	($285,500 to $453,500)	($273,000 to $441,000)	($273,000 to $441,000)
Total Estimated Net Effect on <u>All</u> Federal Funds	**($285,500 to $453,500)**	**($273,000 to $441,000)**	**($273,000 to $441,000)**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Total Estimated Net Effect on FTE	**0**	**0**	**0**

☒ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $250,000 in any of the three fiscal years after implementation of the act or at full implementation of the act.

☐ Estimated Net Effect (savings or increased revenues) expected to exceed $250,000 in any of the three fiscal years after implementation of the act or at full implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS

FUND AFFECTED	FY 2027	FY 2028	FY 2029
Local Government	**$0 or (Unknown)**	**$0 or (Unknown)**	**$0 or (Unknown)**

FISCAL ANALYSIS

ASSUMPTION

§§376.1363-376.2108 – Prior Authorization Provisions

Officials from the **Missouri Consolidated Health Care Plan** (**MCHCP)** state this proposal creates a prior authorization exemption, which would allow providers to skip prior authorization requirements if they qualify by meeting a 90% approval threshold in the 12 months prior. Once this exemption is applied, payment can only be withheld for limited reasons that do not include the service being later found not medically necessary in whole or in part.

It is unknown how many providers serving MCHCP members would qualify for this exemption. For this calculation it is assumed that 15% of providers would qualify. It is also unknown how many cases would be authorized under the exemption that would otherwise be deemed not medically necessary in whole or in part. It is assumed a 5% utilization increase once prior authorization controls are off. This portion of SB 841 would have an estimated impact of $1,300,000 to $2,100,000 for MCHCP.

Oversight does not have information to the contrary and therefore, Oversight will reflect the estimates as provided by the MCHCP.

Oversight assumes the prior authorization exemption could increase health insurance costs for insurance plans. Oversight assumes the cost could be $1,300,000 to $2,100,000 based on MCHCP's response. Therefore, Oversight will the fiscal impact as provided by MCHCP as the following:

General Revenue (64%): ($832,000 to $1,344,000)
Federal Funds (21%): ($273,000 to $441,000)
Other Funds (15%): ($195,000 to $315,000)
Total: ($1,300,000 to $2,100,000)

Officials from the **Department of Commerce and Insurance (DCI)** assume this proposal would create a prior authorization "Gold Card" program, allowing health care providers to bypass prior authorization requirements under certain circumstances. This proposal will likely result in increased consumer and provider complaints.

The department believes the costs of this bill can be absorbed within current appropriations. However, should the cost exceed the anticipated amount, the department would request an increase in FTE and/or appropriations as appropriate through the budget process.

Officials from the DCI assume the cost of the proposal can be absorbed. **Oversight** does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for this agency.

Officials from the **Department of Social Services (DSS)** assume this legislation amends Chapter 376 by adding eight new sections relating to prior authorization of health care services. The sections address a health carrier or utilization review entity not requiring a health care provider to obtain prior authorization for a health care service unless the provider meets certain criteria.

This legislation applies to Chapter 376 and states that a Medicaid managed care organization as defined in section 208.431 shall be considered a health carrier for purposes of sections 376.2100 to 376.2108. Due to this, this legislation would apply to MO HealthNet managed care and there would be a fiscal impact.

The Managed Care Health Plans (HP) have prior authorization processes in place, and this legislation would result in providers not needing to obtain prior authorization for services unless the HP determines that it has approved or would have approved less than 90% of prior authorization requests submitted by that provider for health care services in the most recent evaluation period. MHD estimates that there could be an impact on the administrative component of the rate for the additional reporting, reviewing, and monitoring of the prior authorizations. However, MHD does not have enough information at this time to ascertain whether there would be an impact on the service portion of the capitated rate.

This will require an actuarial analysis estimated to cost $25,000 for this program change.

FY27 Total: $25,000 (GR: $12,500; Federal: $12,500)

Oversight does not have information to the contrary and therefore, Oversight will reflect the estimates as provided by the DSS.

Oversight assumes all local political subdivisions could have a potential negative fiscal impact from various provisions related to insurance coverage. For fiscal note purposes, Oversight will reflect a $0 or Unknown fiscal impact to local political subdivisions.

Officials from the **Missouri Department of Transportation (MoDOT)** assume this bill has no direct impact on the MoDOT-MSHP medical plan but would increase costs for third party administrators which in turn would be passed on to the plan when the contract is renewed. MoDOT officials assume this unknown cost to be less than $250,000 to the State Road Fund.

Oversight does not have information to the contrary and therefore, Oversight will reflect the estimates as provided by MoDOT.

Officials from the **Department of Health and Senior Services** and **Missouri Department of Conservation** each assume the proposal will have no fiscal impact on their respective organizations. **Oversight** does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for these agencies.

Officials from the **Department of Public Safety - Missouri Highway Patrol** defer to the Missouri Department of Transportation for the potential fiscal impact of this proposal.

Oversight only reflects the responses that we have received from state agencies and political subdivisions; however, other cities were requested to respond to this proposed legislation but did not. Upon the receipt of additional responses, Oversight will review to determine if an updated fiscal note should be prepared and seek the necessary approval to publish a new fiscal note. A general listing of political subdivisions included in our database is available upon request.

FISCAL IMPACT – State Government	FY 2027 (10 Mo.)	FY 2028	FY 2029
GENERAL REVENUE			
Cost – MCHCP (§§376.1363 - 376.2108) Prior authorization of health care services p.3	($832,000 to $1,344,000)	($832,000 to $1,344,000)	($832,000 to $1,344,000)
Cost – DSS (§§376.1363 - 376.2108) Actuarial Analysis p.4	($12,500)	$0	$0
ESTIMATED NET EFFECT ON GENERAL REVENUE	**($844,500 to $1,356,500)**	**($832,000 to $1,344,000)**	**($832,000 to $1,344,000)**
FEDERAL FUNDS			
Cost – MCHCP (§§376.2100 to 376.2108) Prior authorization of health care services p.3	($273,000 to $441,000)	($273,000 to $441,000)	($273,000 to $441,000)
Cost – DSS (§§376.1363 - 376.2108) Actuarial Analysis p.4	($12,500)	$0	$0
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**($285,500 to $453,500)**	**($273,000 to $441,000)**	**($273,000 to $441,000)**
OTHER STATE FUNDS			
Cost – MCHCP (§§376.2100 to 376.2108) Prior authorization of health care services p.3	($195,000 to $315,000)	($195,000 to $315,000)	($195,000 to $315,000)

FISCAL IMPACT – State Government	FY 2027 (10 Mo.)	FY 2028	FY 2029
ESTIMATED NET EFFECT ON OTHER STATE FUNDS	**($195,000 to $315,000)**	**($195,000 to $315,000)**	**($195,000 to $315,000)**
STATE ROAD FUND* (1320)			
Cost – MoDOT (§§376.2100 to 376.2108) Prior authorization of health care services p.3	$0 or (Unknown)	$0 or (Unknown)	$0 or (Unknown)
ESTIAMTED NET EFFECT TO THE STATE ROAD FUND	**$0 or (Unknown)**	**$0 or (Unknown)**	**$0 or (Unknown)**

*MoDOT assumes cost to be less than $250,000.

FISCAL IMPACT – Local Government	FY 2027 (10 Mo.)	FY 2028	FY 2029
LOCAL POLITICAL SUBDIVISIONS			
Cost – (§§376.2100 to 376.2108) Prior authorization of health care services p.12	$0 or (Unknown)	$0 or (Unknown)	$0 or (Unknown)
ESTIMATED NET EFFECT ON LOCAL POLITICAL SUBDIVISIONS	**$0 or (Unknown)**	**$0 or (Unknown)**	**$0 or (Unknown)**

FISCAL IMPACT – Small Business

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

FISCAL DESCRIPTION

Currently, provided a patient is an enrollee of a health benefit plan, a utilization review entity is prohibited from revoking, limiting, conditioning, or otherwise restricting a prior authorization for a health care service within 45 working days of the date the health care provider receives the prior authorization. This bill changes the time frame to be the lesser of six months after the date the health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care provider. Additionally, if a health carrier requires a prior

authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, the approval will remain valid for the lesser of 12 months from the date the health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care provider. Failure of a health carrier to comply with these provisions will result in any health care services subject to prior authorization to be automatically deemed authorized by the health carrier for a duration of time of at least the time frames described above.

Currently, any utilization review entity performing prior authorization review must provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. This bill requires a timestamp to be provided to a provider as well. Prior to January 1, 2021, health carriers utilizing prior authorization review were required to develop a single secure electronic prior authorization cover page for all of its health benefit plans utilizing prior authorization review, which would be used by the carrier or its utilization review entity to accept and respond to, and which providers would use to submit, requests for prior authorization. This bill repeals that provision and instead provides that for plan years beginning on or after January 1, 2027, health carriers or utilization review entities are required to implement and maintain a prior authorization application programming interface (API) to respond to requests for prior authorization for health care services, excluding prescription drugs. If the API cannot be implemented in time, the carrier must notify the Department of Commerce and Insurance requesting an extension. Health care providers must use the API to submit requests for prior authorization for health care services, excluding prescription drugs.

The bill requires contracts between health carriers and participating health care providers entered into or renewed on or after January 1, 2027, to include a provision requiring health care providers to submit prior authorization requests via the API; failure to do so will result in the enrollee not being subject to cost sharing in excess of the in-network cost-sharing amount. Additionally, the bill requires that health carriers utilizing prior authorization make available statistics regarding prior authorization approvals and denials for health care services in a readily available format. Carriers must submit the URL to the Department, which must publish the website locations in a central location on the Department's website.

The bill specifies what information must be included. This bill requires that health carriers offering health benefit plans with a managed care component report to the Department a complete list of the health care services for which prior authorization is required. The bill requires health carriers to reduce the scope of claims subject to prior authorizations. To promote consistency among carriers, the Department is required to review the submitted reports and compile an annual report to be published on the Department’s website.

The bill also requires the reporting by health carriers to the Department of aggregated data related to certain practices, including, but not limited to, the number of prior authorization requests, the number of requests approved or denied, and the number of requests for mental health services, behavioral health benefits, and substance use disorders. The bill lists the data required to be reported. The bill requires that contracts between health carriers and health care

providers include a provision for the continuation of prior authorization approvals for enrollees from a previous health carrier for at least 180 days from the effective date of the enrollee's coverage under the new health benefit plan, subject to the terms of the certificate of coverage. At any time during this 180-day period, the new health carrier can perform its own review to grant a prior authorization approval subject to the terms of the certificate of coverage. Additionally, if there is a change in coverage of or approval criteria for a previously authorized health care service, the change in coverage or approval criteria must not affect an enrollee who received prior authorization approval before the effective date of the change through the remainder of the enrollee's plan year. Beginning January 1, 2027, prior authorization is not required unless a determination is made that less than 90% of prior authorization requests submitted by the health care provider in the previous evaluation period, as defined in the bill, were or would have been approved. Entities exempt from these prior authorization requirements may be audited, up to a maximum of two times per year, and exemption may be revoked under specific conditions, such as approval rates dropping below 90% or a significant increase in exempt procedures. Additionally, exemptions are void if providers are found guilty of fraud or abuse.

Online portals may be required for prior authorization submissions, and no adverse determinations are to be finalized unless reviewed by a clinical peer. The bill specifies requirements for notifying the provider of determinations in the bill, requires carriers and utilization review entities to maintain an online portal giving providers access to certain information, and provides that a health carrier or utilization review entity must notify the health care provider no later than 25 days after a determination has been made. Lastly, no health carrier or utilization review entity can deny or reduce payments to a health care provider who had a prior authorization, unless the provider made a knowing and material misrepresentation with the intent to deceive the carrier or utilization review entity, or unless the health care service was not substantially performed. This bill does not apply to MO HealthNet, except with regard to a Medicaid managed care organization as defined by law. The bill also does not apply to providers who have not participated in a health benefit plan offered by the carrier for at least one full evaluation period. This bill should not be construed to authorize providers to provide services outside the scope of their licenses, nor to require health carriers or utilization review entities to pay for care provided outside the scope of a provider's license.

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 Commerce and Insurance
Department of Health and Senior Services
Department of Public Safety - Missouri Highway Patrol
Department of Social Services
Missouri Department of Conservation
Missouri Department of Transportation
Missouri Consolidated Health Care Plan

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