Local Government Mandate Statement
Kentucky Legislative Research Commission
2025 Regular Session

Part I: Measure Information

Bill Request #:	278	**Bill #:**	HB 423 GA
Document ID #:	5233	**Sponsor:**	Representative Kimberly Poore Moser
Bill Title:	AN ACT relating to prior authorization.		

Unit of Government: ☒ City ☒ County ☒ Urban-County ☒ Charter County ☒ Consolidated Local ☒ Unified Local

Office(s) Impacted: Health insurance

Requirement: ☒ Mandatory ☐ Optional

Effect on Powers & Duties: ☒ Modifies Existing ☐ Adds New ☐ Eliminates Existing

Other Fiscal Statement(s) that may exist: ☒ Actuarial Analysis ☐ Corrections Impact ☒ Health Benefit Mandate ☒ State Employee Health Plan

Part II: Bill Provisions and the Estimated Fiscal Impact Relating to Local Government

HB 423 GA Section 1 would create a new section of KRS 304.17A-600 to 304.17A-633 to require that every insurer offer a program in which a participating health care services provider may be exempted from the requirement to obtain prior authorization (PA) for a health care service that requires PA. An insurer or its private review agent would be prohibited from requiring a covered person, authorized person, or participating provider obtain PA for a health care service if, at the time the service was provided, the provider had a PA exemption for that service. Among the requirements for such a program are the following:

1. A participating provider shall receive a PA exemption for a particular health care service if, during the previous evaluation period, the provider met program terms and conditions.
2. The program may not condition a PA exemption on the provider exceeding a 93% approval rate for PA exemption requests for that health care service during an evaluation period;

3. The insurer shall annually evaluate whether a provider qualifies for a PA exemption;
4. The insurer shall notify each provider that qualifies for a PA exemption within 30 days after the annual evaluation;
5. Insurers shall make available to a provider the requirements the provider must meet to participate in the program.

Section 1 (3) would establish several options an insurer may offer including a PA exemption for prescription drugs, a PA exemption to a health care provider group rather than individually for each provider in that group, and conditioning a provider's eligibility to participate in the program on satisfying one or more of the following criteria:

1. The provider has entered into a value-based care agreement with the insurer;
2. The provider has participated in the program for a minimum period not to exceed one year;
3. The provider complies with interoperability standards and has entered into an electronic health record access agreement with the insurer.
4. Require a provider meet utilization criteria for a health care service in the previous evaluation period in order to qualify for a PA exemption for that service; or
5. Authorize an insurer to revoke or suspend a provider's PA exemption if the insurer has evidence the provider has engaged in fraud or abuse, or the providers utilization meets or exceeds prescribed maximum utilization.

Section 1 would apply to any insurer or its private review agent providing or performing utilization review in connection with a health benefit plan and any private review agent performing utilization review functions on behalf of a person providing and administering health benefit plans.

Section 4 would amend KRS 304.17A-611 to prohibit an insurer conducting a retrospective utilization review based only on a provider having a prior authorization exemption under a program offered under Section 1 (3) except to determine if the provider still qualifies for an exception. Timeframes for making a utilization review decision under KRS 304.17A-607 would not apply to a retrospective review conducted to determine if a provider qualifies for an initial or continuing PA exemption under a program offered pursuant to Section 1 (3).

Sections 1 to 4 of the Act would apply to contracts delivered, entered, renewed, extended, or amended on or after January 1, 2027. Section 5 would take effect January 1, 2026. Sections 1 to 4, 6 and 7 would take effect January 1, 2027.

HB 423 would have a negative fiscal impact on local governments that provide health insurance requiring prior authorization for health care services. The fiscal impact of HB 423 GA is unchanged from the fiscal impact of HB 423 HCS.

According to the Fiscal Impact Report for HB 423 submitted February 18, 2025 almost 60% of health plans use a prior authorization exemption program. That report projects

2025 Kentucky average premium per member per month (PMPM) at $711.60, and an impact from the bill on premiums PMPM at $0.05 - $5.29.

Most health insurance plans, and the Kentucky Employees Health Plan (KEHP) in which many local governments participate, do require prior authorization for numerous services, and for certain prescription drugs. Forgoing prior authorization could result in increased utilization of health care services and so cause insurance premiums to increase, which would have a negative fiscal impact on local governments. The American Medical Association believes prior authorization requirements often cause delays in necessary health care, leading to poorer health outcomes and often more expensive treatments. If this is the case it's possible that eliminating prior authorization requirements would have a positive fiscal impact on local governments in the long term.

Data Source(s): Kentucky League of Cities; Kentucky Association of Counties; LRC staff; Internet research re: the American Medical Association; Fiscal Impact Report – BR 278/HB 423 by Lewis & Ellis Actuaries and Consultants

Preparer: MS **Reviewer:** TJ (MDA) **Date:** 2/25/25