



**LEGISLATIVE FISCAL OFFICE**  
**Fiscal Note**

Fiscal Note On: **SB 348** SLS 22RS 400  
 Bill Text Version: **ENGROSSED**  
 Opp. Chamb. Action: **w/ HSE COMM AMD**  
 Proposed Amd.:  
 Sub. Bill For.:

<b>Date:</b> May 24, 2022	1:48 PM	<b>Author:</b> CLOUD
<b>Dept./Agy.:</b> Office of Group Benefits		
<b>Subject:</b> Transparency in Prior Authorizations		<b>Analyst:</b> Patrice Thomas

GROUP BENEFITS PROGRAM EG1 SEE FISC NOTE See Note Page 1 of 1  
 Provides a process for the appeal of denied medical benefits by the Office of Group Benefits. (7/1/22)

Beginning January 1, 2023, proposed law provides that the Office of Group Benefits (OGB) shall require every health plan it offers to furnish in writing or electronically, within 24 hours of a written or oral request by a healthcare provider or covered person, the medical criteria and any other requirements that must be satisfied in order for a particular healthcare service, procedure, or prescription drug to be prior authorized by the health plan. Upon the denial of a prior authorization by a health plan offered through its office, proposed law provides that OGB shall require the health plan to provide with the written notification of the denial a copy of the applicable law, regulation, policy, procedure, or medical criterion or guideline that was used by the health plan to deny the prior authorization or how to access such law, regulation, policy, procedure, or medical criterion or guideline that is publicly accessible. Proposed law effective July 1, 2022.

<b>EXPENDITURES</b>	<u>2022-23</u>	<u>2023-24</u>	<u>2024-25</u>	<u>2025-26</u>	<u>2026-27</u>	<u>5 -YEAR TOTAL</u>
State Gen. Fd.	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>
Agy. Self-Gen.	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Ded./Other	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>
Federal Funds	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>
Local Funds	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<b>\$0</b>
<b>Annual Total</b>						
<b>REVENUES</b>	<u>2022-23</u>	<u>2023-24</u>	<u>2024-25</u>	<u>2025-26</u>	<u>2026-27</u>	<u>5 -YEAR TOTAL</u>
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Federal Funds	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>
Local Funds	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<b>\$0</b>
<b>Annual Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**EXPENDITURE EXPLANATION**

The proposed law requires OGB to provide transparency in prior authorization for all its six (6) health plan vendors. Under the proposed law, if requested by a healthcare provider or plan member, OGB shall require all its health plans to furnish a written or electronic response, within 24 hours, of the prior authorization criteria for healthcare service, procedure, or prescription drug. If prior authorization is denied, OGB shall require all its health plans to provide a copy of the applicable law, regulation, policy, procedure, or medical criterion or guideline that was used in that determination.

OGB is in the process of determining if the current procedures of their fully insured health plan vendors comply with provisions of the proposed law. At the time of publication of this fiscal note, OGB has not responded with any fiscal impact.

**REVENUE EXPLANATION**

There is no anticipated direct material effect on governmental revenues as a result of this measure.

Senate      Dual Referral Rules  
 13.5.1 >= \$100,000 Annual Fiscal Cost {S & H}  
 13.5.2 >= \$500,000 Annual Tax or Fee Change {S & H}

House  
 6.8(F)(1) >= \$100,000 SGF Fiscal Cost {H & S}  
 6.8(G) >= \$500,000 Tax or Fee Increase or a Net Fee Decrease {S}

*Evan Brasseaux*  
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**Evan Brasseaux**  
 Interim Deputy Fiscal Officer