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Bill Analysis

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SUMMARY

- Requires health insurers to make prior authorization data available on their websites in a readily accessible format and submit such data in a report to the Department of Insurance which, in turn, must provide the data to the General Assembly.
- Requires health insurers and the Ohio Department of Medicaid (ODM) to exempt a healthcare provider from prior authorization requirements when at least 90% of the healthcare provider's requests for a service, device, or drug within the prior 12 months have been approved.
- Permits healthcare providers to request evidence from a health insurer or ODM which supports the insurer's or ODM's decision to deny an exemption, and to appeal that decision.
- Prohibits health insurers and ODM from requiring that healthcare providers initiate a request as a condition of receiving an exemption.
- Permits health insurers and ODM to review exemptions after 12 months, and establishes guidelines for the exemption review process.
- Permits a healthcare provider to appeal an exemption revocation.
- Makes repeated violations of the bill by a health insurer an unfair and deceptive practice under the Consumer Sales Protection Act (CSPA).

DETAILED ANALYSIS

Prior authorization exemptions

Prior authorization is a process through which a healthcare provider requests provisional affirmation of coverage from a health insurer or the Ohio Department of Medicaid (ODM) before a service, device, or drug is provided to a patient, and before a claim is submitted for payment.

Insurers and ODM require prior authorization as a condition of approving claims for certain services, devices, and drugs. Review of prior authorization requests purportedly ensures that coverage pays only for medically necessary care.[1]

The bill requires health insuring corporations and sickness and accident insurers (collectively, "health insurers") and ODM or its designee, to grant exemptions to prior requirements under certain circumstances. Specifically, a health insurer or ODM must allow an exemption if both of the following apply:

- The health insurer or ODM has approved at least 90% of the prior authorization requests for the service, device, or drug from a given healthcare provider within the prior 12 months.
- A health care provider or health care provider group has submitted at least 20 prior authorization requests for the service, device, or drug to the health insurer or ODM within the prior 12 months.[2]

The exemption must last at least 12 months, but a health insurer or ODM may choose to extend it for a longer period. The bill permits a healthcare provider that does not receive an exemption to request that the health insurer or ODM provide evidence supporting the decision to deny the exemption. The bill requires a health insurer or ODM to comply with such requests for evidence but limits a healthcare provider to making one request per calendar year for the same service, device, or drug. Additionally, the bill prohibits health insurers or ODM from requiring that a healthcare provider request an exemption before it is granted.[3]

The prior authorization exemption requirement applies to health insurance plans issued on or after January 1, 2027.[4]

Required disclosures and notice

The bill requires a health insurer that applies a prior authorization requirement to make prior authorization data available on its public website in a readily accessible format by the last day of March each year, beginning in 2027. A report must also be compiled and sent to the Department of Insurance to be published on the Department's website and submitted to the General Assembly. The data must include all of the following:

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[1] Prior Authorization Process for Certain Hospital Outpatient Department Services Frequently Asked Questions (PDF), which may be accessed by conducting a keyword "Prior Authorization Process for Certain Hospital Outpatient Department Services" search and navigating to "OPD Frequently Asked Questions (PDF)" on the Centers for Medicare & Medicaid Services' website: cms.gov.

[2] R.C. 1751.72(B)(14), 3923.041(B)(14), 5160.34(B)(13), and 5160.341(A)(1).

[3] R.C. 1751.72(B)(14)(a) through (e), 3923.041(B)(14)(a) through (e), 5160.34(B)(13)(a) through (e), and 5160.341(A) through (D).

[4] R.C. 1751.71(B)(14)(a) and 3923.041(B)(14)(a).

- The percentage of standard and expedited prior authorization requests that were approved, denied, and approved after appeal;
- The percentage of prior authorization requests for which the timeframe for review was extended;
- The average and median amount of time between the submission of a prior authorization request and the response from the health insurer.[5]

When a health insurer or ODM grants a prior authorization exemption, the bill requires that the insurer provide written notice to the healthcare provider that submitted the request. The notice must include all of the following information:

- A statement that the healthcare provider qualifies for an exemption;
- The healthcare service, medical device, or drug to which the exemption applies;
- The dates the exemption begins and ends.[6]

Prior authorization exemption evaluation

Evaluating and revoking exemptions

At the end of the exemption period, a health insurer or ODM may evaluate an exemption granted under the bill. The health insurer or ODM, in conducting an evaluation, must review 20 claims submitted by the healthcare provider, chosen at random. These 20 claims must be from the three months immediately prior to the evaluation, unless there are not 20 relevant claims in those three months. In that case, the health insurer or ODM may review earlier claims.

If less than 90% of the claims reviewed would have been approved based on medical necessity, then the bill permits the health insurer or ODM to revoke the exemption. This standard differs from the requirements for granting the exemption initially, which provide that the exemption must be granted if 90% of the claims in the preceding 12 months are approved for any reason. For an exemption to remain in force, 90% of the reviewed claims must have been *medically necessary*, meaning there is a higher bar to retain the exemption than to receive one in the first place. The bill prohibits a health insurer or ODM from reviewing a healthcare provider's exemption for a particular service, device, or drug more than once every 12 months. If an evaluation does not provide grounds to revoke an exemption, it remains valid for at least 12 more months until the health insurer or ODM is permitted to conduct another evaluation.[7]

The bill requires that the decision to revoke or deny an exemption be made by a healthcare provider licensed in Ohio who practices the same or a similar specialty as the

[5] R.C. 1751.72(B)(13) and 3923.041(B)(13).

[6] R.C. 1751.72(B)(14)(g), 3923.041(B)(14)(g), 5160.34(B)(13)(g), and 5160.341(E).

[7] R.C. 1751.722(B)(14)(h), 3923.041(B)(14)(h), 5160.34(B)(13)(h), and 5160.341(F).

healthcare provider under consideration. That healthcare provider making the decision must also have experience in providing the service, device, or drug covered by the exemption.[8]

If an exemption is revoked, the bill requires health insurers or ODM to provide the healthcare provider with notice containing the information relied upon in making the determination, and a plain language explanation of how to appeal the decision. The bill also clarifies that it does not prevent health insurers or ODM from making an administrative denial of a claim.[9]

Appeals

The bill allows a healthcare provider to appeal a decision to revoke an exemption within 30 days of receiving the notice described above. If the healthcare provider appeals and the decision is upheld, the exemption remains in effect for five days after the decision to uphold the revocation. If an exemption is revoked and the decision is not appealed, the exemption remains in effect for 30 days after the healthcare provider receives notice of the revocation.[10]

Enforcement

A series of violations of the bill's provisions by a health insuring corporation or sickness and accident insurer which, when taken together, constitute a practice or pattern, are considered an unfair and deceptive business practice under the Consumer Sales Protection Act (CSPA). Additionally, the bill permits the Superintendent of Insurance and the Director of Medicaid to adopt rules necessary to implement the provisions of the bill. Those rules are not subject to continuing law provisions concerning the reduction of regulatory restrictions.[11]

Other provisions

The bill extends the definitions in R.C. 5160.34 to the new provisions added to the Medical Assistance Programs chapter of the Revised Code. Among those definitions, the bill clarifies that "prior authorization" includes prospective or utilization review procedures conducted prior to providing a **medical** device, as opposed to a device generally. The bill removes the definition of "utilization review organization," as the term is not used elsewhere in the operative Revised Code sections.[12]

The bill also clarifies that if a healthcare provider submits a request for prior authorization electronically, either ODM or its designee is responsible for responding to the request within 48 hours of receipt by the department for urgent care services, or within ten days of receipt for any

[8] R.C. 1751.72(B)(14)(k), 3923.041(B)(14)(k), 5160.34(B)(13)(k), and 5160.341(I).

[9] R.C. 1751.72(B)(14)(j) and (l), 3923.041(B)(14)(j) and (l), 5160.34(B)(13)(g), (j), and (l), and 5160.341(F)(3).

[10] R.C. 1751.72(B)(14)(d) and (j), 3923.041(B)(14)(d) and (j), 5160.34(B)(13)(d) and (j), and 5160.341(G) and (H).

[11] R.C. 1751.72(E), 3923.041(E), and 5160.34(E).

[12] R.C. 5160.34 (A)(4), and (A)(6).

prior authorization request that is not for an urgent care service. Current law does not expressly permit an ODM designee to respond to such requests.[13]

HISTORY

Action	Date
Introduced	04-01-25

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[13] R.C. 5160.34(B)(4).