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Bill Analysis

Version: As Introduced

Primary Sponsors: Rep. Workman

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SUMMARY

- Requires health insuring corporations, sickness and accident insurers, public employee benefit plans, (collectively, "health insurers") and the Department of Medicaid (ODM) to honor a prior authorization approval if a provider prescribes a change in dosage of the approved drug.
- Requires that the name, specialty, and relevant qualifications of the clinical peer, who is required by continuing law to review prior authorization appeals, to be identified.
- Prohibits health insurers from charging a fee for appealing an adverse prior authorization determination.
- Prohibits health insurers and ODM from retroactively denying a prior authorization for mental health or substance use disorder treatment.
- Specifies that the bill's provisions apply to private insurance policies issued on or after the first day of January following the effective date of the bill.

DETAILED ANALYSIS

Prior authorization

Prior authorization is a process through which a healthcare provider requests provisional affirmation of coverage from a health insurer or the Department of Medicaid (ODM) before a service, device, or drug is provided to a patient, and before a claim is submitted for payment. Under current law, health insuring corporations, sickness and accident insurers, and public employee benefit plans (collectively, "health insurers") and the Medicaid program 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]

Approvals

Current law dictates that the duration for prior authorization requests are governed by the relevant health plan with exceptions for chronic conditions.

The following medications are excluded from 12-month prior approvals:

- Medications that are prescribed for a nonmaintenance condition;
- Medications that have a typical treatment of less than one year;
- Medications that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year or greater, prior authorization period will be given;
- Medications where there is medical or scientific evidence that does not support a 12-month prior approval;
- Medications that are a Schedule I or II controlled substance under continuing Ohio law or any opioid analgesic or benzodiazepine;
- Medications that are not prescribed by an in-network provider as part of a care management system.[2]

Under the bill, a prior authorization approval must be honored by a health insurer or ODM if a provider prescribes a change in dosage of the approved drug.[3]

Appeals

Under current law, health insurers and ODM must have a streamlined appeal process relating to prior authorization denials. For urgent care services, the appeal is to be heard within 48 hours after the health plan issuer receives the appeal. For all other matters, the appeal is to be heard within ten calendar days after the issuer receives the appeal. The appeal must be between the health care practitioner requesting the service and a clinical peer.

The bill requires health insurers and ODM to identify the name, specialty, and relevant qualifications of the clinical peer who evaluates the appeal.[4] Additionally, a health insurer is prohibited from charging a fee for appealing an adverse prior authorization determination.[5]

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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)(6)(e), 3923.041(B)(6)(e), and 5160.34(B)(6)(e).

[3] R.C. 1751.72(B)(6)(f), 3923.041(B)(6)(f), and 5160.34(B)(6)(f).

[4] R.C. 1751.72(B)(12)(c), 3923.041(B)(12)(c), and 5160.34(B)(12)(c).

[5] R.C. 1751.72(B)(12)(e), 3923.041(B)(12)(e), and 5160.34(B)(12)(e).

Prior authorization determinations binding

Except in cases of fraudulent or materially incorrect information, current law prohibits a health insurer or ODM from retroactively denying a prior authorization for a health care service, drug, or device when all of the following are met:

- The health care practitioner submits a prior authorization request to the health insurer or ODM.
- The health insurer or ODM approves the request after determining that all the following that apply to the policy are true:
  - The patient is eligible under the health plan;
  - The health care service, drug, or device is covered under the plan;
  - The service, drug, or device meets the health insurer's or ODM's standards for medical necessity and prior authorization.
- The practitioner renders the service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the practitioner's contract with the health insurer or ODM.
- On the date the health care practitioner renders the prior approved service, drug, or device, (1) the patient is eligible under the health plan, (2) the patient's condition or circumstances related to the patient's care have not changed, and (3) the practitioner submits an accurate claim that matches the information submitted by the practitioner in the approved prior authorization request.

The bill specifies that the prohibition against retroactive denials of prior authorization applies to mental health or substantive abuse disorder treatment. Furthermore, the bill eliminates the requirement that the service, drug, or device meet the health insurer's or ODM's standards for medical necessity and prior authorization. [6]

Application date

The bill's provisions apply to private health insurance policies issued on or after the first day of January following the effective date of the bill.

HISTORY

Action	Date
Introduced	04-01-25

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