Ohio Legislative Service Commission

Bill Analysis

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S.B. 129

131st General Assembly
(As Introduced)

Sens. Gardner and Cafaro, Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner

BILL SUMMARY

- Adopts criteria in relation to health insurance prior authorization requirements.
- Requires the Superintendent of Insurance and the Department of Medicaid (DOM) to adopt a standardized form for the submission of prior authorization requests.
- Requires health plan issuers to use this standardized form.
- Sets standards for the development of the clinical review criteria by which prior authorization requests are judged, i.e. whether or not the health plan issuer will provide coverage for the requested drug or service.
- Requires health plan issuers to enable covered individuals or health service providers to submit prior authorization requests within one year after the effective date of the bill.
- Imposes prior authorization request review deadlines on health plan issuers and designates requests that are not approved or denied during those deadlines as approved.
- Requires health plan issuers to honor prior authorizations for specified time periods.
- Requires prior authorization denials to be made by or in association with a medical professional.
- Requires a health plan issuer that uses prior authorization requirements to make available on its website information about the health benefits products offered by the health plan issuer.

- Specifies, for health plan issuers not related to DOM, that violations of the bill's requirements are considered unfair and deceptive practices.

CONTENT AND OPERATION

Overview

The bill adopts criteria in relation to health insurance prior authorization requirements. Under the bill, a prior authorization requirement is any notification or approval requirement upon which coverage of a drug or health service is dependent. The bill applies to health insuring corporations, sickness and accident insurers, public employee benefit plans, multiple employer welfare corporations, and the Department of Medicaid (DOM), all of which are collectively referred to as health plan issuers in this analysis.[1]

Standardized form

The bill requires the Superintendent of Insurance to adopt a standardized form by which a covered individual may make a prior authorization request or make prior notification. The form is not to exceed two pages in length. The form must include information on how a covered individual is to contact the health plan issuer in question if the prior authorization relates to an urgent medical need. The rules adopting this form must specify criteria that determine when a prior authorization request involves an urgent medical need.[2] The bill requires DOM to adopt a similar standardized form for medical assistance recipients that is to be based on the form adopted by the Superintendent.[3]

Prior authorization requirements

The bill prescribes certain requirements for health plan issuers whose health benefit products implement prior authorization requirements. Under the bill, all health plan issuers must use a standardized form issued by either the Superintendent or DOM, as appropriate, in relation to prior authorization requirements.[4]

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[1] R.C. 1739.05, 1751.72, 3901.90, 3923.041, 5160.33, and 5160.34.

[2] R.C. 3901.90.

[3] R.C. 5160.33.

[4] R.C. 1751.72(B)(1), 3923.041(B)(1), and 5160.34(B)(1).

Clinical review criteria

A prior authorization requirement must be based on clinical review criteria guidelines that meet all of the following standards:

- They are developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with the health plan issuer or a utilization review organization that is conducting utilization review of the health plan issuer;
- They are based on high quality studies, research, and medical practice;
- They are continuously updated through a review of new evidence and research.

The clinical review criteria must be created by a transparent process that does all of the following:

- Minimizes biases and conflicts of interest;
- Explains the relationship between treatment options and outcomes;
- Rates the quality of the evidence supporting recommendations;
- Considers relevant patient subgroups and preferences.[5]

Prior authorization requests submitted via electronic system

One year after the effective date of the bill, health plan issuers are required to permit medical services providers to access the prior authorization form through the electronic software system. It is unclear exactly to what "electronic software system" refers. Similarly, one year after the effective date of the bill, a prior authorization requirement must permit a health plan issuer, a pharmacy benefit manager, or other payer to accept prior authorization forms through a secure electronic transmission. This secure electronic transmission cannot be a fax machine.[6]

Response deadlines

Under the bill, a health plan issuer must respond to prior authorization requests in a timely manner. For urgent medical needs, the health plan issuer must respond within 24 hours from the time the request is received by the health plan issuer. For all

[5] R.C. 1751.72(B)(2), 3923.041(B)(2), and 5160.34(B)(2).

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

other medical needs, the deadline is 48 hours. If the health plan issuer does not respond within these time limits, a prior authorization request is deemed approved. Also, these deadlines do not apply to emergency medical services or trauma care.[7]

Honoring prior authorization approvals

The bill requires health plan issuers to honor a prior authorization for the less of the following:

- Twelve months from the date of the approval;
- The last day of the covered person in question's eligibility under the health plan.

Once a health plan issuer has issued an authorization pursuant to a prior authorization request, the health plan issuer may not retroactively deny coverage for the approved medical service or drug.[8]

Prior authorization denials

Under the bill, adverse prior authorization determinations, i.e. denials of coverage, must be made by either of the following:

- A physician or nurse under the direction of the director of the health plan issuer;
- A panel of appropriate health care reviewers if at least one member of the panel is a physician who is board certified or eligible to render the same specialty as the medical service under review.[9]

Health benefit product information accessibility

A health plan issuer that uses prior authorization requirements must make available on its website information about the health benefits product offered by the health plan issuer and that must clearly identify the health benefit product to which the information applies. The information must be accessible to an individual before the individual enrolls in a health benefit product and must include all of the following:

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

[8] R.C. 1751.72(B)(6) and (7), 3923.041(B)(6) and (7), and 5160.34(B)(6) and (7).

[9] R.C. 1751.72(B)(9), 3923.041(B)(9), and 5160.34(B)(9).

- A written description of any prior authorization requirements and statistics regarding prior authorization approvals and denials;
- The most recently published drug formulary, so that a covered individual may see all drugs covered by the health benefit product in one place;
- Information on the health benefit product's tier structure for prescription drugs and the cost-sharing structure for each tier;
- The drug utilization management system for each drug placed on the formulary, including prior authorization and step therapy protocol requirements and drug quantity limits;
- Copayment amounts and coinsurance percentages that apply to the health benefit product.[10]

Miscellaneous provisions

The bill makes other requirements related to prior authorization that are not easily categorized. A health plan issuer must establish a streamlined appeal process whereby a covered individual can appeal an adverse prior authorization decision.[11] This appeal requirement does not apply to DOM, which already has appeal procedures. Also, new prior authorization requirements must be disclosed to covered individuals or health service providers at least 60 days prior to the effective date of the new requirement.[12] And lastly, a health plan issuer must allow a previously made prior authorization request to be amended within 48 hours of the rendering of a medical service, if the service rendered is different than the approved service; this provision appears to apply to requests made after the service is rendered. This provision does not appear to apply to the dispensing of drugs.[13]

Unfair and deceptive practice

With regard to health plan issuers that are not related to DOM, a failure to comply with these requirements is considered an unfair and deceptive practice.[14] Continuing law unchanged by the bill enables the Superintendent to conduct a hearing

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

[11] R.C. 1751.72(B)(12) and 3923.041(B)(12).

[12] R.C. 1751.72(B)(10), 3923.041(B)(10), and 5160.34(B)(10).

[13] R.C. 1751.72(B)(8), 3923.041(B)(8), and 5160.34(B)(8).

[14] R.C. 1751.72(C) and 3923.041(C).

to determine if an unfair or deceptive practice has occurred. If, subsequent to the hearing, the Superintendent determines that an insurer has engaged in an unfair or deceptive practice, then the Superintendent is required to issue a cease and desist order. Additionally, the Superintendent may suspend the violator's license, require the termination of the employment of the person responsible for the violation, or issue a fine or other possible sanctions.[15]

Definitions

The bill defines the following terms:

"Covered person" means a person receiving coverage for health services under a health benefit product issued by a health plan issuer.

"Emergency medical service" means medical services performed by first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, and paramedics. The term includes services performed before or during any transport of a patient, including transports between hospitals and transports to and from helicopters.

"Nurse" means an individual who holds a current, valid nursing license authorized to practice as a registered nurse.

"Physician" means an individual authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

"Prior authorization requirement" means any practice implemented by a health plan issuer in which coverage of a health care service or drug is dependent upon a covered person, or a health care provider, notifying the health plan issuer that the service or drug is going to be provided or requesting or receiving approval from the plan issuer for the service or drug. "Prior authorization" includes any precertification, notification, or referral program, or a prospective or utilization review conducted prior to providing a health care service or drug.

"Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition that are medically appropriate for a particular patient are covered by a health plan issuer.

"Trauma care" means the assessment, diagnosis, transportation, treatment or rehabilitation of a trauma victim by emergency medical service personnel or by a physician, nurse, physician assistant, respiratory therapist, physical therapist,

[15] R.C. 3964.05(B) and R.C. 3901.22(A), not in the bill.

chiropractor, occupational therapist, speech-language pathologist, audiologist, or psychologist licensed to practice as such in Ohio or another jurisdiction.

"Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

"Utilization review organization" means an entity that conducts utilization reviews, other than a health plan issuer performing a review of its own health benefit products.[16]

HISTORY

ACTION	DATE
Introduced	03-16-15

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[16] R.C. 1751.72(A), 3901.90(A), 3923.041(A), and 5160.34(A).