Ohio Legislative Service Commission

Sub. Bill Comparative Synopsis

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Sub. S.B. 129

131st General Assembly
(H. Insurance)

This table summarizes how the latest substitute version of the bill differs from the immediately preceding version. It addresses only the topics on which the two versions differ substantively. It does not list topics on which the two bills are substantively the same.

Topic	Previous Version (As Passed by the Senate)	Sub. Version (LSC 131 0033-11)
Electronic requests	Requires prior authorization requests to be submitted and accepted through a secure electronic transmission and specifies that a proprietary portal that does not use NCPDP SCRIPT standard is not an electronic transmission *(R.C. 1751.72(B)(2), 3923.081(B)(2), and 5119.25(B)(2))*.	Same, but specifies that the proprietary portal is for prescription drug requests *(R.C. 1751.72(B)(2), 3923.081(B)(2), and 5119.25(B)(2))*.
	Requires the health plan issuer to provide a written receipt to the health care practitioner acknowledging that the prior authorization request was received *(R.C. 1751.72(B)(5)(a), 3923.041(B)(5)(a), and 5119.25(B)(5)(a))*.	Same, but specifies that the receipt must be electronic *(R.C. 1751.72(B)(5)(a), 3923.041(B)(5)(a), and 5119.25(B)(5)(a))*.

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Response deadlines	Requires the health plan issuer to respond to a prior authorization request within the following timeframes from the date a request is received with all the necessary information: • One business day for urgent care services; • Five business days for other services *(R.C. 1751.72(B)(4)(a), 3923.041(B)(4)(a), and 5160.34(B)(4)(a)).* Specifies that the above timeframes do not apply to emergency medical services or trauma care *(R.C. 1751.72(B)(4)(a), 3923.041(B)(4)(a), and 5160.34(B)(4)(a)).*	Similar, but requires the health plan issuer to respond to the prior authorization request within 48 hours for urgent care services, and ten calendar days for other services from the time the request is received with all information necessary to support the request *(R.C. 1751.72(B)(4)(a), 3923.041(B)(4)(a), and 5160.34(B)(4)(a)).* Specifies that the timeframes do not apply to emergency services *(R.C. 1751.72(B)(4)(a), 3923.041(B)(4)(a), and 5160.34(B)(4)(a)).*
Incomplete requests	For incomplete responses, requires the health plan issuer to respond within the timeframes listed above once the issuer has all the necessary information *(R.C. 1751.72(B)(4)(b)(ii) and (5), 3923.041(B)(4)(b)(ii) and (5), and 5160.34(B)(4)(b)(ii) and (5)).*	Requires the health care practitioner to provide an electronic receipt to the health plan issuer acknowledging the request for additional information, and requires the practitioner to provide the necessary information within 72 hours of receipt of the request *(R.C. 1751.72(B)(4)(b)(ii) and (5)(b), 3923.041(B)(4)(b)(ii) and (5)(b), and 5160.34(B)(4)(b)(ii) and (5)(b)).*

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12-month prior approval for chronic conditions	Requires a 12-month prior approval for chronic conditions and permits a health plan issuer to require a health care practitioner to submit information indicating that the patient's chronic condition has not changed no earlier than six months and no later than seven months after the initial prior approval request was submitted *(R.C. 1751.72(B)(6)(c), 3923.041(B)(6)(c), and 5160.34(B)(6)(c)).*	Requires the frequency of information to be consistent with medical or scientific evidence, but not more frequently than quarterly *(R.C. 1751.72(B)(6)(c), 3923.041(B)(6)(c), and 5160.34(B)(6)(c)).*
	No provision.	Requires the request for information and the response to be in an electronic format, which can be by email or other electronic communication.
	No provision.	If the health care practitioner does not respond to the request for information within five calendar days from the date of receipt, the health plan issuer may terminate the 12-month approval *(R.C. 1751.72(B)(6)(c), 3923.041(B)(6)(c), and 5160.34(B)(6)(c)).*
Exclusions to 12-month approvals	No provision.	Excludes the following 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 do not support a 12-month prior approval;

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		• Medications that are 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 *(R.C. 1751.72(B)(6)(e), 3923.041(B)(6)(e), and 5160.34(B)(6)(e)).*
	Permits, but does not require, a health plan issuer to provide a 12-month approval for a drug that meets all of the following characteristics: • The drug is prescribed for an individual with a complex or rare medical condition. • The drug costs $600 or more for up to a 30-day supply. • The drug is not typically stocked at retail pharmacies. • The drug requires difficult or unusual delivery, preparation, or handling, or it requires enhanced patient education, management, or support *(R.C. 1751.72(B)(7), 3923.041(B)(7), and 5160.34(B)(7)).* Stipulates that a health plan issuer is not required to provide a 12-month approval for a drug that has a typical treatment plan of less than one year *(R.C. 1751.72(B)(8), 3923.041(B)(8), and 5160.34(B)(8)).*	Instead requires the drug to meet the following characteristics: • The drug is prescribed or administered to treat a rare medical condition (a condition that affects fewer than 200,000 people in the United States) and pursuant to medical or scientific evidence. • The drug is not a Schedule I or II controlled substance or any opioid analgesic or benzodiazepine *(R.C. 1751.72(B)(7), 3923.041(B)(7), and 5160.34(B)(7)).* Instead stipulates that nothing in the bill's provisions regarding 12-month approvals prohibits the substitution of any drug that has received a 12-month prior approval when there is a release of an FDA-approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the FDA Orange Book *(R.C. 1751.72(B)(8),*

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		3923.041(B)(8), and 5160.34(B)(8)).
Appeal process	Requires a health plan issuer to establish a streamlined reconsideration and appeal process *(R.C. 1751.72(B)(12), 3923.041(B)(12), and 5160.34(B)(12)).*	Similar, but only requires an appeal process *(R.C. 1751.72(B)(12), 3923.041(B)(12), and 5160.34(B)(12)).*
	Requires the reconsideration to be conducted according to the following timelines: • For urgent care services, the health plan issuer must conduct the reconsideration within one business day after receipt of the request for reconsideration. • For nonurgent care services, the reconsideration must be conducted within two business days of receipt of the request *(R.C. 1751.72(B)(12)(a), 3923.041(B)(12)(a), and 5160.34(B)(12)(a)).*	No provision.
	Specifies that the reconsideration is to be conducted between the health care practitioner and the reviewer who made the adverse determination *(R.C. 1751.72(B)(12)(b), 3923.041(B)(12)(b), and 5160.34(B)(12)(b)).*	No provision.
	Permits the health care practitioner to appeal an adverse reconsideration determination and requires the appeal to be conducted within the following timelines: • For urgent care services, one business day after receipt of the appeal; • For nonurgent care services, five business days after receipt of the appeal *(R.C. 1751.72(B)(12)(c) and (d), 3923.041(B)(12)(c) and (d), and*	Requires an appeal to be considered within the following timeframes: • For urgent care services, 48 hours after receipt of the appeal; • For all other matters, ten calendar days after receipt of the appeal *(R.C. 1751.72(B)(12)(a) and (b), 3923.041(B)(12)(a) and (b), and 5160.34(B)(12)(a) and (b)).*

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	5160.34(B)(12)(c) and (d)).	
External review	Permits the health care practitioner or the covered person to request an external review under the relevant law if the appeal does not resolve the dispute *(R.C. 1751.72(B)(12)(f), 3923.041(B)(12)(f), and 5160.34(B)(12)(f)).*	Permits the covered person or an authorized representative of the covered person to request an external review of the relevant law, to the extent the relevant law is applicable with respect to health plans that are not related to Medicaid *(R.C. 1751.72(B)(12)(d), 3923.041(B)(12)(d), and 5160.34(B)(12)(d)).*
Retroactive denials	Requires a health plan issuer to honor an approved prior authorization determination relating to benefit coverage and medical necessity if obtained not more than 60 days prior to the date the service, drug, or device is provided or received, except in cases of fraudulent or materially incorrect information *(R.C. 1751.72(C)(1), 3923.041(C)(1), and 5160.34(C)(1)).*	No provision.
	Stipulates that a health plan issuer is not required to cover a service, drug, or device if, due to the covered individual switching plans, the service, drug, or device is no longer covered at the time it is provided *(R.C. 1751.72(C)(1), 3923.041(C)(1), and 5160.34(C)(1)).*	No provision.
	No provision.	Except in cases of fraudulent or materially incorrect information, prohibits a health plan issuer 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 plan issuer. • The health plan issuer approves the

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		request after determining that (1) the patient is eligible under the health benefit plan, (2) the service, drug, or device is covered under the plan, and (3) the service, drug, or device meets the health plan issuer's standards for medical necessity and prior authorization. • The health care 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 plan issuer. • On the date the health care practitioner renders the prior approved health care service, drug, or device, (1) the patient is eligible under the health benefit plan, (2) the patient's condition or circumstances related to the patient's care have not changed, and (3) the health care practitioner submits an accurate claim that matches the information submitted by the health care practitioner in the approved prior authorization request *(R.C. 1751.72(C), 3923.041(C), and 5160.34(C)).*
	No provision.	Provides that if a health care practitioner submits a claim that includes an unintentional error that results in the claim not matching the information originally submitted by the practitioner in the approved prior authorization request, upon receiving a denial, the practitioner may resubmit the claim with the information that matches the information in the approved prior authorization

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		(R.C. 1751.72(C)(5), 3923.041(C)(5), and 5160.34(C)(5)).
Unenforceable provisions	Prohibits a health plan issuer from imposing a restriction or condition in relation to prior authorizations that limits, restricts, or effectively eliminates the force of determinations made in accordance with the bill's provisions *(R.C. 1751.72(D), 3923.041(D), and 5160.34(D)).*	Instead provides that any provision of a contractual arrangement between a health plan issuer and a health care practitioner or health plan beneficiary that is contrary to the bill's provisions is unenforceable *(R.C. 1751.72(D), 3923.041(D), and 5160.34(D)).*
Current address	No provision.	Requires all participating health care practitioners to promptly notify the health plan issuer of any changes to the practitioner's electronic mail or standard mail address *(R.C. 1751.72(B)(10)(c), 3923.041(B)(10)(c), and 5160.34(B)(10)(c)).*
Effective date	Establishes specific effective dates before or after which the bill's provisions must be in effect *(various)*.	Similar, but for health plans that are not related to Medicaid, instead specifies that the bill's provisions are effective for policies issued on or after the specified effective date *(R.C. 1739.05, 1751.72, and 3923.041)*.
Rule-making authority	No provision.	Permits the Superintendent of Insurance and the Director of Medicaid to adopt rules in accordance with the Administrative Procedure Act as necessary to enforce the bill's provisions *(R.C. 1751.72(F), 3923.041(F), and 5160.34(E))*.

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Application to certain insurance plans and federal laws	No provision.	With respect to the bill's provisions outside of Medicaid, states that the bill does not apply to certain types of specialty insurance plans, such as a specified accident, disability income, hospital indemnity, or vision coverage; workers compensation; or coverage under Medicare or certain military plans, or any coverage issued as a supplement to that coverage *(R.C. 1751.72(G) and 3923.041(G))*.
Definitions	"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 *(R.C. 4765.01, not in the bill)*.	"Emergency services" means: (1) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition; (2) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital *(R.C. 1753.28, not in the bill)*.
	"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, chiropractor, occupational therapist, speech-language pathologist, audiologist, or psychologist licensed to practice	No provision.

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	in Ohio or another jurisdiction *(R.C. 4765.01, not in the bill)*.	
	No provision.	"Urgent care services" means a medical care or other service for a condition where application of the timeframe for making routine or nonlife threatening care determinations is either of the following: • Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; • In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request *(R.C. 1751.72(A)(9), 3923.041(A)(9), and 5160.34(A)(5))*.
Recovery housing	No provision.	Changes to July 1, 2017, the effective dates for certain provisions of existing law relating to recovery housing operated by local boards of alcohol, drug addiction, and mental health services *(R.C. 340.034, 5119.25, and Sections 3 and 5)*.

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