Ohio Legislative Service Commission

Synopsis of House Committee Amendments*

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Sub. S.B. 129

131st General Assembly
(H. Insurance)

Electronic prior authorization

Specifies that a proprietary portal for prescription drug requests that does not use NCPDP SCRIPT standard is not a permissible secure, electronic communication for prior authorization requests.

Provides that the required receipt to be issued by a health plan issuer to a health care practitioner acknowledging a prior authorization request must be electronic.

Response deadlines

Requires a health plan issuer to respond to a prior authorization request within 48 hours for urgent care services, instead of one business day, and ten calendar days for nonurgent services, instead of five business days.

Removes the reference to emergency medical services and trauma care in the exception to the above deadlines, and instead only excludes emergency services.

Provides a definition of "emergency services."

Incomplete requests

Requires a health care practitioner to provide a written receipt acknowledging a request for necessary information from the health plan issuer.

Additionally requires the practitioner to provide the necessary information within 72 hours.

Honoring prior authorization approvals

Regarding a 12-month prior approval for a chronic condition, requires that the frequency of information requested by a health plan issuer to indicate that a patient's chronic condition has not changed is to be consistent with medical or scientific

* This synopsis does not address amendments that may have been adopted on the House Floor.

evidence, but not more frequently than quarterly, instead of no earlier than six months and no later than seven months after the initial prior approval request was submitted.

Requires the request for information and the response to be in an electronic format, which can be by email or other electronic communication.

Stipulates that if the health care practitioner does not respond within five calendar days from the date of receipt, the health plan issuer may terminate the 12-month approval.

Excludes certain types of drugs from 12-month approvals.

Modifies the list of drugs for which a health care provider may, but is not required to, provide a 12-month approval.

Provides that the substitution of a 12-month prior approved drug is not prohibited when there is a release of an FDA-approved comparable brand product or generic counterpart of a brand product that is listed as therapeutically equivalent in the FDA Orange Book.

Appeal process

Revises the reconsideration and appeal processes to only include an appeal process.

Requires an appeal to be considered within 48 hours for urgent care services, instead of one business day, and ten calendar days for nonurgent services, instead of five business days.

External review

Additionally permits an authorized representative of a covered person to request an external review under the applicable law and eliminates health care practitioners as persons authorized to request an external review.

Specifies that, with regard to health plans that are not related to Medicaid, the external review is permitted to the extent that the review procedures under continuing Insurance Law are applicable.

Retroactive denials

Establishes new criteria under which a health plan issuer is prohibited from retroactively denying a prior authorization, instead of requiring a health plan issuer to honor an approved prior authorization if obtained not more than 60 days prior to administering the service, drug, or device.

Permits a health care practitioner to resubmit a claim that was denied because of an unintentional error resulting in the claim not matching the prior authorization request.

Unenforceable provisions

Makes unenforceable 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.

Current address

Requires all participating health care practitioners to promptly notify a health plan issuer of any changes to the practitioner's electronic or standard mail address.

Effective date

For health policies not related to Medicaid, provides that the bill's provisions are effective for policies issued on or after the specified effective date.

Rule-making authority

Grants the Superintendent of Insurance and the Director of Medicaid the authority to adopt rules in accordance with the Administrative Procedure Act.

Application to certain insurance plans and federal laws

With respect to health plans that are not Medicaid, specifies that the bill does not apply to certain types of specialty insurance plans, or coverage under Medicare or certain military plans or any coverage issued as a supplement to that coverage.

Definitions

Modifies the definition of "urgent care services."

Recovery housing

Changes from September 15, 2016, to July 1, 2017, the effective dates for certain provisions of law relating to recovery housing operated by local boards of alcohol, drug addiction, and mental health services.