Ohio Legislative Service Commission

Bill Analysis

Erika Padgett

Sub. S.B. 129*

131st General Assembly
(As Reported by H. Insurance)

Sens. Gardner and Cafaro, Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner, Tavares, Eklund, Hughes, Jones, Obhof, Patton, Sawyer, Schiavoni, Thomas, Uecker

BILL SUMMARY

- Adopts criteria in relation to health insurance prior authorization requirements.
- Imposes prior authorization request response deadlines on health plan issuers.
- Requires health plan issuers to honor prior authorizations for specified time periods.
- Specifies, for health plan issuers not related to the Department of Medicaid, that violations of the bill's requirements are considered unfair and deceptive practices under the Insurance Law.
- Changes the effective date from September 15, 2016, to July 1, 2017, several provisions relating to alcohol, drug addiction, and mental health boards and recovery housing.

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 service, drug, or device is dependent. The bill applies to health insuring corporations, sickness and accident insurers, public employee benefit plans, multiple employer welfare arrangements, and the Department of Medicaid, all of which are collectively referred to as health plan issuers in this

* This analysis was prepared before the report of the House Insurance Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

analysis.[1] The bill's Medicaid provisions use slightly different terminology that has been adapted for a simpler explanation of the bill.

The bill adopts various effective dates for each of its provisions. The effective date for each provision is noted below.

Prior authorization requests submitted via electronic system

Under the bill, health plan issuers must permit health care practitioners to access prior authorization forms through the applicable software system. It is unclear exactly to what "applicable software system" refers. Similarly, a health plan issuer, or other payer acting on behalf of the issuer, must accept prior authorization requests through a secure electronic transmission. For prior prescription benefit authorization requests, the health plan issuer must use NCPDP SCRIPT standard ePA transactions. For prior medical benefit requests, the health plan issuer must use standards established by the Council for Affordable Quality Health Care on Operating Rules for Information Exchange. Neither a proprietary payer portal for prescription drug requests that does not use NCPDP SCRIPT standard nor a facsimile are considered a secure electronic transmission.

Note, however, that the bill authorizes a health care practitioner and a health plan issuer to enter into a contract under which the health plan issuer agrees to process prior authorization requests that are not submitted electronically because of the financial hardship electronic submission would impose or if Internet access is restricted where the practitioner is located.

These provisions apply to private insurance policies issued on or after January 1, 2018. The effective date of these provisions for Medicaid plans is January 1, 2018.[2]

Response deadlines

Under the bill, a health plan issuer must issue an electronic receipt acknowledging a prior authorization request has been received and respond to prior authorization requests in a timely manner. For urgent care services, the health plan issuer must respond within 48 hours from the time the request is received by the health plan issuer with all information necessary to support the request. For any prior authorization that is not related to an urgent care service, the deadline is ten calendar days. These deadlines do not apply to emergency services.

---

*Insert standard footnote

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

[2] R.C. 1751.72(B)(1) to (3), 3923.041(B)(1) to (3), and 5160.34(B)(1) to (3).

The bill requires the response to indicate whether an approval request is approved, denied, or requires more information. If the request is denied, the issuer must provide the specific reason for the denial. If the request is considered incomplete, the issuer must identify the additional information that is required. The health care practitioner must provide an electronic receipt to the issuer acknowledging that the request for additional information was received. The practitioner must also provide the additional required information requested by the health plan issuer within 72 hours of the time the request for additional information is received.

These provisions apply to private insurance policies issued on or after January 1, 2018. The effective date of these provisions for Medicaid plans is January 1, 2018.[3]

Honoring prior authorization approvals

The bill requires health plan issuers, for a prior approval related to a chronic condition, to honor a prior authorization request for a drug for the lesser 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.

The duration for all other prior authorization requests are governed by the relevant health plan. Additionally, a health plan issuer may require a health care practitioner to submit information indicating that the patient's chronic condition has not changed. A health plan issuer can ask for this information consistent with medical or scientific evidence, but not more frequently than quarterly. The request for more information from the issuer and the response by the practitioner must be in an electronic format, which may be by email or other electronic communication. If the health care practitioner does not respond within five calendar days, the health plan issuer may terminate the 12-month approval. Additionally, a 12-month prior approval is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance prescribing that the drug in question is no longer approved or safe for the intended purpose.[4]

The bill makes certain exclusions to the 12-month approval period. The following medications are excluded from 12-month prior approvals:

[3] R.C. 1751.72(B)(4) and (5), 3923.041(B)(4) and (5), and 5160.34(B)(4) and (5).

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

- 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.[5]

A health plan issuer can, but is not required to, provide a 12-month approval for a medication that meets either of the following characteristics:

- The medication 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 medication is not a Schedule I or II controlled substance or any opioid analgesic or benzodiazepine.[6]

The bill also stipulates that it does not prohibit 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.[7]

These provisions apply to private insurance policies issued on or after January 1, 2017. The effective date of these provisions for Medicaid plans is January 1, 2017.[8]

---

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

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

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

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

Retrospective review

The bill requires a health plan issuer, upon written request, to conduct a retrospective review for a claim that is submitted for a service where prior authorization was originally required, but not obtained, if the service in question meets all of the following characteristics:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

Once the written request and all necessary information is received, the health plan issuer must review the claim for coverage and medical necessity. The health plan issuer cannot deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

These provisions apply to private insurance policies issued on or after January 1, 2017. The effective date of these provisions for Medicaid plans is January 1, 2017.[9]

Health benefit product information accessibility

A health plan issuer that uses prior authorization requirements must make available to participating health care practitioners on its website or provider portal a list of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete. The health plan issuer must also make available on its website information about the policies, contracts, or agreements offered by the health plan issuer that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists. This provision applies to private insurance policies issued on or after January 1, 2017. The effective date of this provision for Medicaid plans is January 1, 2017.[10]

The bill also requires a health plan issuer to disclose to all participating health care practitioners any new prior authorization requirements at least 30 days prior to the effective date of the changes. The notice may be sent via email or standard mail and

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

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

must be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but must include specific information on where the health care practitioner may locate the information on the health plan issuer's website or, if applicable, the health plan issuer's portal.

All participating health care practitioners must promptly notify the health plan issuer of any changes to the practitioner's email or standard mail address.

These provisions apply to private insurance policies issued on or after January 1, 2017. The effective date of these provisions for Medicaid plans is January 1, 2017.[11]

Appeal process

The bill requires a health plan issuer to establish 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 health plan issuer receives the appeal. The appeal must be between the health care practitioner requesting the service in question and a clinical peer. If the appeal does not resolve the disagreement, then either of the following applies:

- For policies that are not related to Medicaid, the covered person or an authorized representative may request an external review under the Insurance Law, to the extent those provisions are applicable.

- For Medicaid plans, the appeal process must permit the Medicaid recipient to further appeal pursuant to the Medicaid Law.

This provision applies to private insurance policies issued on or after January 1, 2018. The effective date of this provision for Medicaid plans is January 1, 2018.[12]

Prior authorization determinations binding

Except in cases of fraudulent or materially incorrect information, the bill 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.

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

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

- The health plan issuer approves the request after determining that (1) the patient is eligible under the health plan, (2) the health care 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 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 health care practitioner submits an accurate claim that matches the information submitted by the health care practitioner in the approved prior authorization request.

The bill further 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.

Finally, the bill 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.

These provisions apply to private insurance policies issued on or after January 1, 2017. The effective date of these provisions for Medicaid plans is January 1, 2017.[13]

Unfair and deceptive practice

With regard to health plan issuers that are not related to the Department of Medicaid, committing a series of violations of the bill's requirements that, taken together, constitute a practice or pattern is considered an unfair and deceptive practice under the Insurance Law. Continuing law unchanged by the bill enables the Superintendent to conduct a hearing 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

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

violator's license, require the termination of the employment of the person responsible for the violation, or issue a fine or other possible sanctions.

This provision applies to private insurance policies issued on or after January 1, 2017.[14]

Rule-making authority

The bill permits the Superintendent of Insurance and the Director of Medicaid to adopt rules in accordance with the Administrative Procedure Act as necessary to enforce its provisions.[15]

Applicability to certain plans and federal laws

The bill specifies that with respect to health plans that are not related to Medicaid, it's provisions do not apply to the following types of coverage:

- A policy, contract, certificate, or arrangement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital, indemnity, supplemental coverage, specified disease, or vision care;
- Coverage issued as a supplement to liability insurance;
- Insurance arising out of workers' compensation or similar law;
- Automobile medical payment insurance;
- Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- A Medicare supplement policy of insurance as defined by the Superintendent by rule;
- Coverage under a plan through Medicare or the federal Employees Benefit Program;
- Any coverage issued under federal law with respect to certain veterans' benefits, and any coverage issued as a supplement to that coverage.[16]

[14] R.C. 1751.72(E) and 3923.041(E) and R.C. 3901.22, not in the bill.

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

Boards of alcohol, drug addiction, and mental health services and recovery housing

Withholding funds

Continuing law establishes requirements for each local board of alcohol, drug addiction, and mental health services. The bill modifies the effective date of certain requirements with respect to the withholding of certain funds otherwise allocated to a board of alcohol, drug addiction, and mental health services (ADAMHS board) from September 15, 2016, to July 1, 2017, to require both of the following on that date:

- Recovery housing is to not be owned or operated by an ADAMHS board unless, among other criteria, the board owns and operates the recovery housing on July 1, 2017;

- The Director of Mental Health and Addiction Services must withhold funds otherwise allocated to an ADAMHS board if the board's use of state and federal funds fails to comply with the board's approved budget or if the Director disapproves the board's plan, budget, or statement of services.

- The bill delays to July 1, 2017, certain revisions of the Recovery Housing Law made in the Main Operating Budget, Am. Sub. H.B. 64 of the 131st General Assembly, relating to recovery housing.[17]

Definitions

The bill defines the following terms:

"Chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

"Clinical peer" means a health care practitioner in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

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

---

[16] R.C. 1751.72(G) and 3923.041(G).

[17] R.C. 340.04 and 5119.25 and Sections 3 to 7 and, by reference, Sections 110.12 and 812.40 of Am. Sub. H.B. 64 of the 131st General Assembly.

"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.[18]

"Fraudulent or materially incorrect information" means any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the covered person in question.

"Health care practitioner" means a dentist or dental hygienist, a nurse, an optometrist, an optician, a pharmacist, a physician, a physician's assistant, a psychologist, a chiropractor, a hearing aid dealer or fitter, a speech-language pathologist or audiologist, an occupational therapist, a physical therapist, a professional counselor or social worker, a dietician, a respiratory care professional, or an emergency care professional.

"NCPDP SCRIPT standard" means the National Council for Prescription Drug Programs SCRIPT standard version 201310 or the most recent standard adopted by the U.S. Department of Health and Human Services.

"Prior authorization requirement" means any practice implemented by a health plan issuer in which coverage of a health care service, device, or drug is dependent upon a covered person or a health care practitioner obtaining approval from the health plan issuer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

"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;

[18] R.C. 1753.28, not in the bill.

- 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.

"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.[19]

HISTORY

ACTION	DATE
Introduced	03-16-15
Reported, S. Insurance	12-09-15
Passed Senate (33-0)	12-09-15
Reported, H. Insurance	---

S0129-RH-131.docx/emr

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