Ohio Legislative Service Commission

Final Analysis

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Sub. S.B. 129

131st General Assembly
(As Passed by the General Assembly)

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

Reps. Bishoff, DeVitis Henne, Amstutz, Anielski, Antani, Boyd, Brown, Burkley, Conditt, Craig, Cupp, Green, Hambley, Huffman, Lepore-Hagan, McClain, Patterson, Rogers, Schaffer, Sears, R. Smith, Sprague

Effective date: September 13, 2016; certain provisions effective September 15, 2016, and July 1, 2017

ACT SUMMARY

- Adopts criteria addressing 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 act's requirements are considered unfair and deceptive practices under the Insurance Law.
- Delays until July 1, 2017, certain laws regarding the continuum of care that boards of alcohol, drug addiction, and mental health services are required to establish.

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CONTENT AND OPERATION

Overview

The act adopts criteria addressing health insurance prior authorization requirements. Under the act, a prior authorization requirement is any notification or approval requirement upon which coverage of a service, drug, or device is dependent. The act 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 analysis.[1] Note that the act's Medicaid provisions use slightly different terminology than what is used in this analysis in order to provide a simpler explanation of the act.

The act applies its provisions beginning on various effective dates. The application date for each provision is noted below.

Prior authorization requests submitted via electronic system

Under the act, health plan issuers must permit health care practitioners to access prior authorization forms through the "applicable software system." 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 of the following are considered a secure electronic transmission under the act:

- A proprietary payer portal for prescription drug requests that does not use NCPDP SCRIPT standard;
- A facsimile.

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

Note, however, that the act authorizes a health care practitioner and a health plan issuer to enter into a contract under which the 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. They likewise apply to Medicaid plans beginning January 1, 2018.[2]

Response deadlines

Under the act, 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, as federal law prohibits the application of prior authorization requirements to emergency services.[3]

The act requires the response to indicate whether the 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. They likewise apply to Medicaid plans beginning January 1, 2018.[4]

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

[3] 29 C.F.R. 2590.715-2719A(b).

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

Honoring prior authorization approvals

Duration of approval; approval for a chronic condition

The act 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'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 issuer's request for more information and the practitioner's response must be in an electronic format, which may be by email or other electronic communication. If the practitioner does not respond within five calendar days, the 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 is no longer approved or safe for the intended purpose.[5]

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;

[5] 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 not prescribed by an in-network provider as part of a care management system.[6]

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.[7]

The act 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.[8]

These provisions apply to private insurance policies issued on or after January 1, 2017. They likewise apply to Medicaid plans beginning January 1, 2017.[9]

Retrospective review

The act 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.

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

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

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

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

Once the written request and all necessary information is received, the health plan issuer must review the claim for coverage and medical necessity. The 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. They likewise apply to Medicaid plans beginning January 1, 2017.[10]

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 for the prior authorization request to be considered complete. The issuer must also make available on its website information about the policies, contracts, or agreements it offers that clearly identifies specific services, drugs, or devices for which prior authorization is required. This provision applies to private insurance policies issued on or after January 1, 2017. It likewise applies to Medicaid plans beginning January 1, 2017.[11]

The act also requires a health plan issuer to disclose to all participating health care practitioners any new prior authorization requirements at least 30 days before the effective date of the changes. The notice may be sent via email or standard mail and 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 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. They likewise apply to Medicaid plans beginning January 1, 2017.[12]

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

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

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

Appeal process

The act 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 issuer receives the appeal. The appeal must be between the health care practitioner requesting the service and a clinical peer. If the appeal does not resolve the disagreement, then either of the following applies:

- For non-Medicaid policies, the covered person or an authorized representative may request an external review under the Insurance Law, to the extent those provisions apply.

- 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. It likewise applies to Medicaid plans beginning January 1, 2018.[13]

Prior authorization determinations binding

Except in cases of fraudulent or materially incorrect information, the act 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 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 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,

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

(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.

If a health care practitioner submits a claim that includes an unintentional error that results in the claim not matching the information originally submitted 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 act 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 act's provisions is unenforceable.

These provisions apply to private insurance policies issued on or after January 1, 2017. They likewise apply to Medicaid plans beginning January 1, 2017.[14]

Unfair and deceptive practice

With regard to non-Medicaid health plan issuers, committing a series of violations of the act'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 act enables the Superintendent of Insurance 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, the Superintendent must issue a cease and desist order. Additionally, the Superintendent may suspend the violator's license, require 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.[15]

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

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

Rule-making authority

The act 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.[16]

Applicability to certain plans and federal laws

The act specifies that with respect to non-Medicaid health plans, its 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.[17]

Definitions related to prior authorization

The act defines the following terms:

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

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

"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.

"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

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

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;
- 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]

Delayed effective date of ADAMHS board continuum of care revisions

The act delays until July 1, 2017, the effective date of recent revisions to laws governing the continuum of care to be provided by local alcohol, drug addiction, and mental health services (ADAMHS) boards. These revisions – enacted in 2014 and 2015 – originally were scheduled to take effect September 15, 2016.[20]

The same delay implemented by this act also is implemented by H.B. 483 of the 131st General Assembly, which passed the General Assembly on the same day as did this act.

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

[20] R.C. 340.034 and 5119.25; Sections 3 to 7.

Description of delayed revisions

In general, the revisions to the law governing the continuum of care delayed by the act:

(1) Required that the addiction and mental health services that are part of the continuum of care include intensive and other supports, recovery support, prevention and wellness management, sub-acute detoxification, and an array of treatment and support services for all levels of opioid and co-occurring drug addiction;

(2) Required that the array of treatment and support services for all levels of opioid and co-occurring drug addiction include at least ambulatory and sub-acute detoxification, nonintensive and intensive outpatient services, medication-assisted treatment, peer mentoring, residential treatment services, recovery housing, and 12-step approaches;

(3) Established requirements and options for the recovery housing that is part of the array of treatment and support services, including requirements regarding who may and may not own and operate the recovery housing and an expansion of the definition "recovery housing" to include housing for individuals recovering from alcoholism as well as drug addiction;

(4) Required an ADAMHS board's proposed budget to identify funds the board has available for the array of treatment and support services required to be included in the continuum of care;

(5) Required the Department of Mental Health and Addiction Services to disapprove an ADAMHS board's proposed budget if the proposed budget would not make available in the board's service district the essential elements required to be included in the continuum of care;

(6) Required the Department to withhold funds otherwise to be allocated to an ADAMHS board if the board's use of federal or state funds fails to comply with the board's approved budget and if the Department disapproves all or part of the board's annual community addiction and mental health services plan, budget, or statement of services;

(7) Established duties for community addiction services providers regarding the treatment and support services required to be included in an ADAMHS board's continuum of care, including requirements regarding waiting lists and reports of information to ADAMHS boards;

(8) Required ADAMHS boards to compile the information they receive from community addiction services providers and to make certain determinations regarding denied applications for services included in the array of treatment and support services for all levels of opioid and co-occurring drug addiction;

(9) Required ADAMHS boards to report to the Department the information they compile and determine and all other information the Department requires;

(10) Required the Department to make the reports it receives from ADAMHS boards available on its website.

HISTORY

ACTION	DATE
Introduced	03-16-15
Reported, S. Insurance	12-09-15
Passed Senate (33-0)	12-09-15
Reported, H. Insurance	05-24-16
Passed House (96-0)	05-25-16
Senate concurred in House amendments (33-0)	05-25-16

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