OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 130
135th General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Miller

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SUMMARY

- Requires health insurers and the Ohio Department of Medicaid (ODM) to make prior authorization data available on their public websites in a readily accessible format.
- Requires health insurers and ODM to exempt a healthcare provider from prior authorization requirements when at least 80% of the healthcare provider's requests for a service, device, or drug within the prior 12 months have been approved.
- Permits healthcare providers to request evidence from a health insurer or ODM which supports the insurer's or ODM's decision to deny an exemption, and to appeal that decision.
- Prohibits health insurers and ODM from requiring that healthcare providers initiate a request as a condition of receiving an exemption.
- Permits health insurers and ODM to review exemptions after 12 months, and establishes guidelines for the exemption review process.
- Permits a healthcare provider to appeal an exemption revocation.
- Makes repeated violations of the bill an unfair and deceptive practice under the Consumer Sales Protection Law (CSPL).

DETAILED ANALYSIS

Prior authorization exemptions

Prior authorization is a process through which a healthcare provider requests provisional affirmation of coverage from a health insurer or the Ohio Department of Medicaid (ODM) before a service, device, or drug is provided to a patient, and before a claim is submitted

for payment. Insurers and ODM require prior authorization as a condition of approving a claim for certain services, devices, and drugs. Review of prior authorization requests purportedly ensures that coverage pays only for medically necessary care.[1]

The bill requires health insuring corporations, sickness and accident insurers, and ODM or its designee (collectively, "health insurers"), to grant exemptions to those requirements under certain circumstances. If a health insurer has a prior authorization requirement for a service, device, or drug, and it has approved at least 80% of the prior authorization requests for that service, device, or drug from a given healthcare provider within the prior 12 months, the health insurer must exempt that provider from the prior authorization requirement for that service, device, or drug. This exemption must last at least 12 months, but a health insurer may choose to extend it for a longer period.[2]

The bill permits a healthcare provider that does not receive an exemption to request that the health insurer provide evidence supporting its decision to deny the exemption. The bill requires a health insurer to comply with these requests for evidence, but limits a healthcare provider to making one such request per calendar year for the same service, device, or drug. Additionally, the bill prohibits health insurers from requiring that a healthcare provider request an exemption before it is granted.[3]

Required disclosures and notice

The bill requires a health insurer that applies a prior authorization requirement to make prior authorization data available on its public website in a readily accessible format. The data must include all of the following:

- The specialty of the healthcare provider requesting the prior authorization;
- Whether the prior authorization is for a healthcare service, a medical device, or a drug;
- The indication for use of the service, device, or drug under the prior authorization;
- If the prior authorization request was denied, the reason for the denial;
- If the approval or denial of a request was appealed, and the result of the appeal;
- The amount of time between the submission of a prior authorization request and the response from the health insurer.[4]

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[1] Prior Authorization Process for Certain Hospital Outpatient Department Services Frequently Asked Questions (PDF), which may be accessed by conducting a keyword "Prior Authorization Process for Certain Hospital Outpatient Department Services" search and navigating to "OPD Frequently Asked Questions (PDF)" on the Centers for Medicare & Medicaid Services' website: cms.gov.

[2] R.C. 1751.722(A), 3923.043(A), and 5160.342(A).

[3] R.C. 1751.722(B) and (D), 3923.043(B) and (D), and 5160.342(B) and (D).

[4] R.C. 1751.721, 3923.042, and 5160.341.

When a health insurer grants a prior authorization exemption, the bill requires that the insurer provide written notice to the healthcare provider that submitted the request. The notice must include all of the following information:

- A statement that the healthcare provider qualifies for an exemption;
- The healthcare service, medical device, or drug to which the exemption applies;
- The dates the exemption begins and ends.[5]

Prior authorization exemption evaluation

Evaluating and revoking exemptions

After 12 months, a health insurer may evaluate an exemption granted under the bill. The health insurer conducting an evaluation must review ten claims submitted to the insurer by the healthcare provider, chosen at random. These ten claims must be from the three months immediately prior to the evaluation, unless there are not ten relevant claims in those three months. In that case, the health insurer may review earlier claims.[6]

If less than 80% of the claims reviewed would have been approved based on medical necessity, then the bill permits the health insurer to revoke the exemption. This standard differs from the requirements for granting the exemption initially, which provide that the exemption must be granted if 80% of the claims in the preceding 12 months are approved for any reason. For an exemption to remain in force, 80% of the reviewed claims must have been *medically necessary*, meaning there is a higher bar to retain the exemption than to receive one in the first place. The bill prohibits a health insurer from reviewing a healthcare provider's exemption for a particular service, device, or drug more than once every 12 months. If an evaluation does not provide grounds to revoke an exemption, it remains valid for at least 12 more months until the health insurer is permitted to conduct another evaluation.[7]

The bill requires that the decision to revoke or deny an exemption be made by a healthcare provider licensed in Ohio who practices the same or a similar specialty as the healthcare provider under consideration. That healthcare provider making the decision must also have experience in providing the service, device, or drug covered by the exemption.[8]

If an exemption is revoked, the bill requires health insurers to provide the healthcare provider with notice containing the information relied upon in making the determination, and a plain language explanation of how to appeal the decision. The bill also clarifies that it does not prevent health insurers from making an administrative denial of a claim.[9]

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[5] R.C. 1751.722(E), 3923.043(E), and 5160.342(E).

[6] R.C. 1751.722(F)(1) and (2), 3923.043(F)(1) and (2), and 5160.342(F)(1) and (2).

[7] R.C. 1751.722(F)(3)(a) and (4), 3923.043(F)(3)(a) and (4), and 5160.342(F)(3)(a) and (4).

[8] R.C. 1751.722(I), 3923.043(I), and 5160.342(I).

[9] R.C. 1751.722(F)(3)(b) and (J), 3923.043(F)(3)(b) and (J), and 5160.342(F)(3)(b) and (J).

Appeals

The bill allows a healthcare provider to appeal a decision to revoke an exemption within 30 days of receiving the notice described above. If the healthcare provider appeals and the decision is upheld, the exemption remains in effect for five days after the decision to uphold the revocation. If an exemption is revoked and the decision is not appealed, the exemption remains in effect for 30 days after the healthcare provider receives notice of the revocation.[10]

Enforcement

A series of violations of the bill's provisions by a health insuring corporation or sickness and accident insurer which, when taken together, constitute a practice or pattern, are considered an unfair and deceptive business practice under the Consumer Sales Protection Law (CSPL). Additionally, the bill permits the Superintendent of Insurance and the Director of Medicaid to adopt rules necessary to implement the provisions of the bill.[11]

Other provisions

The bill extends the definitions in R.C. 5160.34 to the new provisions added to the Medical Assistance Programs chapter of the Revised Code. Among those definitions, the bill clarifies that "prior authorization" includes prospective or utilization review procedures conducted prior to providing a **medical** device, as opposed to a device generally. The bill removes the definition of "utilization review organization," as the term is not used elsewhere in the operative Revised Code sections.[12]

The bill also clarifies that if a healthcare provider submits a request for prior authorization electronically, either ODM or its designee is responsible for responding to the request within 48 hours of receipt by the department for urgent care services, or within ten days of receipt for any prior authorization request that is not for an urgent care service. Current law does not expressly permit an ODM designee to respond to such requests.[13]

HISTORY

Action	Date
Introduced	03-23-23

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[10] R.C. 1751.722(G) and (H), 3923.043(G) and (H), and 5160.342(G) and (H).

[11] R.C. 1751.723, 3923.044, and 5160.34(E).

[12] R.C. 5160.34(A), (A)(4), and (A)(6).

[13] R.C. 5160.34(B)(4).