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Substitute Bill Comparative Synopsis

Sub. H.B. 130

135th General Assembly

House Insurance

Logan Briggs, Attorney

This table summarizes how the latest substitute version of H.B. 130 (I_135_0725-2) differs from the As Introduced 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.

Previous Version (As Introduced)	Latest Version (I_135_0725-2)
Prior authorization exemptions	
Requires health insuring corporations, sickness and accident insurers, and the Medicaid program to exempt a service, device, or drug from a prior authorization requirement under certain conditions *(R.C. 1751.722(A)(1), 3923.043(A)(1), and 5160.342(A)(1))*.	Removes the requirement with respect to drugs *(R.C. 1751.722(A)(1), 3923.043(A)(1), and 5160.342(A)(1))*.
Requires the exemption only if, during the 12 months preceding the exemption period, the health insurance corporation, sickness and accident insurer, or the Medicaid program approved at least 80% of the prior authorization requests submitted by the health care provider for the service, device, or drug *(R.C. 1751.722(A)(1), 3923.043(A)(1), and 5160.342(A)(1))*.	Increases the threshold for previously approved prior authorization requests from 80% to 95% *(R.C. 1751.722(A)(1)(a), 3923.043(A)(1)(a), and 5160.342(A)(1)(a))*.
No provision.	Specifies that claims that "would have been approved," count as approvals for the purposes of the 95% threshold *(R.C. 1751.722(A)(1)(a), 3923.043(A)(1)(a), and 5160.342(A)(1)(a))*.
No provision.	Clarifies that the required prior authorization exemptions also apply to requests by health care provider groups which meet the requirements, in addition to individual providers *(R.C. 1751.722(A)(1), 3923.043(A)(1), and 5160.342(A)(1); conforming changes throughout the bill)*.

Previous Version (As Introduced)	Latest Version (I_135_0725-2)
No provision.	Requires a health care provider or provider group to submit at least 20 prior authorization requests for the service or device during the 12 months preceding the exemption period to qualify for a prior authorization exemption *(R.C. 1751.722(A)(1)(b), 3923.043(A)(1)(b), and 5160.342(A)(1)(b))*.
Requires, at the end of a 12-month exemption period, each health insuring corporation, sickness and accident insurer, and the Medicaid program to review ten claims from the preceding three months, unless there are fewer than ten claims during that period *(R.C. 1751.722(F), 3923.043(F), and 5160.342(F))*.	Increases the number of reviewed claims from 10 to 20 *(R.C. 1751.722(F)(2), 3923.043(F)(2), and 5160.342(F)(2))*.
Permits a health insuring corporation, a sickness and accident insurer, or the Medicaid program to revoke a prior authorization exemption after such evaluation if less than 80% of the claims reviewed would have been approved based on medical necessity *(R.C. 1751.722(F)(3)(a), 3923.043(F)(3)(a), and 5160.342(F)(3)(a))*.	Increases the percentage of reviewed claims which would have been approved from 80% to 95% *(R.C. 1751.722(F)(3)(a), 3923.043(F)(3)(a), and 5160.342(F)(3)(a))*.
Payment to providers	
No provision.	Prohibits a health insuring corporation, a sickness and accident insurer, or the Medicaid program from denying or reducing payment for a health care service or medical device provided under the bill's prior authorization exemption merely because it was provided by a health care provider or health care provider group that is different than the provider or group that requested the exemption. Specifies that the prohibition does not apply if the provider or group "knowingly and materially" misrepresents the health care service or medical device or fails to substantially perform the service or provide the device. *(R.C. 1751.722(D)(2), 3923.043(D)(2), and 5160.342(C)(2))*.
Prior authorization data disclosure	
Requires a health insuring corporation, sickness and accident insurer, and the Medicaid program to make prior authorization data available on its public website in a readily accessible format if it applies a prior authorization requirement *(R.C. 1751.721(A), 3923.042(A), and 5160.341(A))*.	Also requires the data to be updated annually on or before April 1 *(R.C. 1751.721(A)(1), 3923.042(A)(1), and 5160.341(A))*.

Previous Version (As Introduced)	Latest Version (I_135_0725-2)
No provision.	Requires health insuring corporations and sickness and accident insurers to submit the prior authorization data to the Superintendent of Insurance each year no later than April 1 *(R.C. 1751.721(A)(2) and 3923.042(A)(2))*.

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