

**As Introduced**

**131st General Assembly**

**Regular Session**

**2015-2016**

**S. B. No. 129**

**Senators Gardner, Cafaro**

**Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite,  
Oelslager, Lehner**

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**A BILL**

To amend section 1739.05 and to enact sections 1  
1751.72, 3901.90, 3923.041, 5160.33, and 5160.34 2  
of the Revised Code to amend the law related to 3  
the prior authorization requirements of 4  
insurers. 5

**BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:**

**Section 1.** That section 1739.05 be amended and sections 6  
1751.72, 3901.90, 3923.041, 5160.33, and 5160.34 of the Revised 7  
Code be enacted to read as follows: 8

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 9  
that is created pursuant to sections 1739.01 to 1739.22 of the 10  
Revised Code and that operates a group self-insurance program 11  
may be established only if any of the following applies: 12

(1) The arrangement has and maintains a minimum enrollment 13  
of three hundred employees of two or more employers. 14

(2) The arrangement has and maintains a minimum enrollment 15  
of three hundred self-employed individuals. 16

(3) The arrangement has and maintains a minimum enrollment 17

of three hundred employees or self-employed individuals in any 18  
combination of divisions (A) (1) and (2) of this section. 19

(B) A multiple employer welfare arrangement that is 20  
created pursuant to sections 1739.01 to 1739.22 of the Revised 21  
Code and that operates a group self-insurance program shall 22  
comply with all laws applicable to self-funded programs in this 23  
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 24  
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 25  
3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 3923.30, 26  
3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 27  
3924.031, 3924.032, and 3924.27 of the Revised Code. 28

(C) A multiple employer welfare arrangement created 29  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 30  
shall solicit enrollments only through agents or solicitors 31  
licensed pursuant to Chapter 3905. of the Revised Code to sell 32  
or solicit sickness and accident insurance. 33

(D) A multiple employer welfare arrangement created 34  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 35  
shall provide benefits only to individuals who are members, 36  
employees of members, or the dependents of members or employees, 37  
or are eligible for continuation of coverage under section 38  
1751.53 or 3923.38 of the Revised Code or under Title X of the 39  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 40  
Stat. 227, 29 U.S.C.A. 1161, as amended. 41

**Sec. 1751.72.** (A) As used in this section: 42

(1) "Covered person" means a person receiving coverage for 43  
health services under a policy, contract, or agreement issued by 44  
a health insuring corporation. 45

(2) "Emergency medical service" and "trauma care" have the 46

same meanings as in section 4765.01 of the Revised Code. 47

(3) "Nurse" means an individual who holds a current, valid license issued under Chapter 4723. of the Revised Code authorizing the practice of nursing as a registered nurse. 48  
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(4) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery. 51  
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(5) "Prior authorization requirement" means any practice implemented by a health insuring corporation in which coverage of a health care service or drug is dependent upon a covered person, or a health care provider, notifying the health insuring corporation that the service or drug is going to be provided or requesting or receiving approval from the health insuring corporation. "Prior authorization" includes any precertification, notification, or referral program, or a prospective or utilization review conducted prior to providing a health care service or drug. 55  
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(6) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition that are medically appropriate for a particular patient are covered by a health insuring corporation. 65  
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(7) "Utilization review" and "utilization review organization" have the same meanings as in section 1751.77 of the Revised Code. 70  
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(B) If a policy, contract, or agreement issued by a health insuring corporation contains a prior authorization requirement, then the health insuring corporation shall do all of the 73  
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<u>following:</u>	76
<u>(1) Use the prior authorization form adopted by the</u>	77
<u>superintendent of insurance under section 3901.90 of the Revised</u>	78
<u>Code for all prior authorization requests or notifications made</u>	79
<u>under a prior authorization requirement.</u>	80
<u>(2) Have the prior authorization requirement be based on</u>	81
<u>clinical review criteria guidelines that are all of the</u>	82
<u>following:</u>	83
<u>(a) Developed and endorsed by an independent,</u>	84
<u>multidisciplinary panel of experts not affiliated with the</u>	85
<u>health insuring corporation or a utilization review organization</u>	86
<u>that is conducting utilization review of the health insuring</u>	87
<u>corporation;</u>	88
<u>(b) Based on high quality studies, research, and medical</u>	89
<u>practice;</u>	90
<u>(c) Created by a transparent process that does all of the</u>	91
<u>following:</u>	92
<u>(i) Minimizes biases and conflicts of interest;</u>	93
<u>(ii) Explains the relationship between treatment options</u>	94
<u>and outcomes;</u>	95
<u>(iii) Rates the quality of the evidence supporting</u>	96
<u>recommendations;</u>	97
<u>(iv) Considers relevant patient subgroups and preferences.</u>	98
<u>(d) Continuously updated through a review of new evidence</u>	99
<u>and research.</u>	100
<u>(3) Beginning one year after the effective date of this</u>	101
<u>section, permit medical providers to access the prior</u>	102

authorization form through the provider's electronic software 103  
system. 104

(4) Beginning one year after the effective date of this 105  
section, permit the health insuring corporation, a pharmacy 106  
benefit manager responsible for handling prior authorization 107  
requests, or other payer to accept prior authorization forms 108  
through a secure electronic transmission. For purposes of 109  
division (B) (4) of this section, a facsimile is not considered a 110  
secure electronic transmission. 111

(5) Respond to all prior authorization requests within 112  
twenty-four hours for urgent medical needs, and forty-eight 113  
hours for all other medical needs, from the time the request is 114  
received by the health insuring corporation. If the health 115  
insuring corporation does not respond within the applicable time 116  
period, the request shall be automatically approved. Division 117  
(B) (5) of this section does not apply to emergency medical 118  
service or trauma care. 119

(6) Honor a prior authorization approval for an approved 120  
medical service or drug for the lesser of the following from the 121  
date of the approval: 122

(a) Twelve months; 123

(b) The last day of the covered person's eligibility under 124  
the policy, contract, or agreement. 125

(7) Once a health insuring corporation has issued a prior 126  
authorization approval, not retroactively deny coverage for the 127  
approved medical service or drug. 128

(8) Permit a prior authorization request to be amended 129  
within forty-eight hours of the rendering of a medical service 130  
approved through the prior authorization if the rendered service 131

is different than the approved service. 132

(9) Ensure that an adverse prior authorization decision be 133  
made by either of the following: 134

(a) A physician or nurse under the direction of the 135  
director of the health insuring corporation; 136

(b) A panel of appropriate health care reviewers if at 137  
least one member of the panel is a physician who is board 138  
certified or eligible to render the same specialty as the 139  
medical service under review. 140

(10) Disclose to all participating medical providers and 141  
covered persons any new prior authorization requirement at least 142  
sixty days prior to the effective date of the new requirement. 143

(11) Make available on its web site information about the 144  
policies, contracts, or agreements offered by the health 145  
insuring corporation that clearly identifies the specific 146  
policy, contract, or agreement to which the information applies. 147  
The information shall be accessible to an individual before the 148  
individual enrolls in a policy, contract, or agreement and shall 149  
include all of the following: 150

(a) A written description of any prior authorization 151  
requirements and statistics regarding prior authorization 152  
approvals and denials; 153

(b) The most recently published drug formulary for an 154  
individual to view in one location covered prescription drugs; 155

(c) Information on the policy, contract, or agreement's 156  
tier structure for prescription drugs and the cost-sharing 157  
structure for each tier; 158

(d) The drug utilization management system for each drug 159

placed on the formulary, including prior authorization and step 160  
therapy protocol requirements and drug quantity limits; 161

(e) Copayment amounts and coinsurance percentages that 162  
apply to the policy, contract, or agreement. 163

(12) Establish a streamlined appeal process whereby a 164  
covered person can appeal an adverse prior authorization 165  
decision. 166

(C) Failure to comply with division (B) of this section 167  
shall be considered an unfair and deceptive practice under 168  
sections 3901.19 to 3901.26 of the Revised Code. 169

**Sec. 3901.90.** (A) As used in this section: 170

(1) "Covered person" means a person receiving coverage for 171  
health services under a policy, contract, agreement, or plan 172  
issued by a health plan issuer. 173

(2) "Health plan issuer" means a health insuring 174  
corporation, a sickness and accident insurer, a public employee 175  
benefit plan, or a multiple employer welfare arrangement. 176

(3) "Prior authorization requirement" means any practice 177  
implemented by a health plan issuer in which coverage of a 178  
health care service or drug is dependent upon a covered person, 179  
or a health care provider, notifying the health plan issuer that 180  
the service or drug is going to be provided or requesting or 181  
receiving approval from the health plan issuer. "Prior 182  
authorization" includes any precertification, notification, or 183  
referral program, or a prospective or utilization review 184  
conducted prior to providing a health care service. 185

(4) "Utilization review" has the same meaning as in 186  
section 1751.77 of the Revised Code. 187

(B) The superintendent shall adopt by rule a standard form 188  
by which a covered person may request prior authorization under 189  
a prior authorization requirement. The form shall not exceed two 190  
pages in length. 191

The rules shall specify criteria to determine when a prior 192  
authorization request involves an urgent medical need and the 193  
standard form shall include language whereby a covered person or 194  
health care provider may notify the health plan issuer that the 195  
request involves an urgent medical need. 196

**Sec. 3923.041.** (A) As used in this section: 197

(1) "Covered person" means a person receiving coverage for 198  
health services under a policy of sickness and accident 199  
insurance or a public employee benefit plan. 200

(2) "Emergency medical service" and "trauma care" have the 201  
same meanings as in section 4765.01 of the Revised Code. 202

(3) "Nurse" means an individual who holds a current, valid 203  
license issued under Chapter 4723. of the Revised Code 204  
authorizing the practice of nursing as a registered nurse. 205

(4) "Physician" means an individual authorized under 206  
Chapter 4731. of the Revised Code to practice medicine and 207  
surgery, osteopathic medicine and surgery, or podiatric medicine 208  
and surgery. 209

(5) "Prior authorization requirement" means any practice 210  
implemented by either a sickness and accident insurer or a 211  
public employee benefit plan in which coverage of a health care 212  
service or drug is dependent upon a covered person, or a health 213  
care provider, notifying the insurer or plan that the service or 214  
drug is going to be provided or requesting or receiving approval 215  
from the insurer or plan. "Prior authorization" includes any 216

precertification, notification, or referral program, or a 217  
prospective or utilization review conducted prior to providing a 218  
health care service or drug. 219

(6) "Step therapy protocol" means a protocol or program 220  
that establishes the specific sequence in which prescription 221  
drugs for a specified medical condition that are medically 222  
appropriate for a particular patient are covered by a policy of 223  
sickness and accident insurance or a public employee benefit 224  
plan. 225

(7) "Utilization review" and "utilization review 226  
organization" have the same meanings as in section 1751.77 of 227  
the Revised Code. 228

(B) If a policy issued by a sickness and accident insurer 229  
or a public employee benefit plan contains a prior authorization 230  
requirement, then the insurer or plan shall do all of the 231  
following: 232

(1) Use the prior authorization form adopted by the 233  
superintendent of insurance under section 3901.90 of the Revised 234  
Code for all prior authorization requests or notifications made 235  
under a prior authorization requirement. 236

(2) Have the prior authorization requirement be based on 237  
clinical review criteria guidelines that are all of the 238  
following: 239

(a) Developed and endorsed by an independent, 240  
multidisciplinary panel of experts not affiliated with the 241  
policy or plan or a utilization review organization that is 242  
conducting utilization review of the policy or plan; 243

(b) Based on high quality studies, research, and medical 244  
practice; 245

<u>(c) Created by a transparent process that does all of the</u>	246
<u>following:</u>	247
<u>(i) Minimizes biases and conflicts of interest;</u>	248
<u>(ii) Explains the relationship between treatment options</u>	249
<u>and outcomes;</u>	250
<u>(iii) Rates the quality of the evidence supporting</u>	251
<u>recommendations;</u>	252
<u>(iv) Considers relevant patient subgroups and preferences.</u>	253
<u>(d) Continuously updated through a review of new evidence</u>	254
<u>and research.</u>	255
<u>(3) Beginning one year after the effective date of this</u>	256
<u>section, permit medical providers to access the prior</u>	257
<u>authorization form through the provider's electronic software</u>	258
<u>system.</u>	259
<u>(4) Beginning one year after the effective date of this</u>	260
<u>section, permit the policy or plan, a pharmacy benefit manager</u>	261
<u>responsible for handling prior authorization requests, or other</u>	262
<u>payer to accept prior authorization forms through a secure</u>	263
<u>electronic transmission. For purposes of division (B) (4) of this</u>	264
<u>section, a facsimile is not considered a secure electronic</u>	265
<u>transmission.</u>	266
<u>(5) Respond to all prior authorization requests within</u>	267
<u>twenty-four hours for urgent medical needs, and forty-eight</u>	268
<u>hours for all other medical needs, from the time the request is</u>	269
<u>received by the insurer or plan. If the insurer or plan does not</u>	270
<u>respond within the applicable time period, the request shall be</u>	271
<u>automatically approved. Division (B) (5) of this section does not</u>	272
<u>apply to emergency medical service or trauma care.</u>	273

(6) Honor a prior authorization approval for an approved medical service or drug for the lesser of the following from the date of the approval: 274  
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(a) Twelve months; 277

(b) The last day of the covered person's eligibility under the policy or plan. 278  
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(7) Once an insurer or plan has issued a prior authorization approval, not retroactively deny coverage for the approved medical service or drug. 280  
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(8) Permit a prior authorization request to be amended within forty-eight hours of the rendering of a medical service approved through the prior authorization if the rendered service is different than the approved service. 283  
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(9) Ensure that an adverse prior authorization decision be made by either of the following: 287  
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(a) A physician or nurse under the direction of the director of the insurer or plan; 289  
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(b) A panel of appropriate health care reviewers if at least one member of the panel is a physician who is board certified or eligible to render the same specialty as the medical service under review. 291  
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(10) Disclose to all participating medical providers and covered persons any new prior authorization requirement at least sixty days prior to the effective date of the new requirement. 295  
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(11) Make available on its web site information about the policies or plans offered by the insurer or plan that clearly identifies the specific policy or plan to which the information applies. The information shall be accessible to an individual 298  
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before the individual enrolls in a policy or plan and shall 302  
include all of the following: 303

(a) A written description of any prior authorization 304  
requirements and statistics regarding prior authorization 305  
approvals and denials; 306

(b) The most recently published drug formulary for an 307  
individual to view in one location covered prescription drugs; 308

(c) Information on the policy or plan's tier structure for 309  
prescription drugs and the cost-sharing structure for each tier; 310

(d) The drug utilization management system for each drug 311  
placed on the formulary, including prior authorization and step 312  
therapy protocol requirements and drug quantity limits; 313

(e) Copayment amounts and coinsurance percentages that 314  
apply to the policy or plan. 315

(12) Establish a streamlined appeal process whereby a 316  
covered person can appeal an adverse prior authorization 317  
decision. 318

(C) Failure to comply with division (B) of this section 319  
shall be considered an unfair and deceptive practice under 320  
sections 3901.19 to 3901.26 of the Revised Code. 321

**Sec. 5160.33.** The department of medicaid shall establish a 322  
standardized form to be used by medical assistance recipients 323  
and individuals acting on the behalf of medical assistance 324  
recipients to request prior authorization for health care 325  
services and items that are covered by a medical assistance 326  
program and require prior authorization. The department may 327  
provide for the form to be completed and submitted to the 328  
department or its designee, including a medicaid managed care 329

organization, through an electronic submission process. To the 330  
extent possible, the form shall be modeled on the standardized 331  
prior authorization form adopted by the superintendent of 332  
insurance under section 3901.90 of the Revised Code. 333

**Sec. 5160.34.** (A) As used in this section: 334

(1) "Emergency medical service" and "trauma care" have the 335  
same meanings as in section 4765.01 of the Revised Code. 336

(2) "Nurse" means an individual who holds a current, valid 337  
license issued under Chapter 4723. of the Revised Code 338  
authorizing the practice of nursing as a registered nurse. 339

(3) "Physician" means an individual authorized under 340  
Chapter 4731. of the Revised Code to practice medicine and 341  
surgery, osteopathic medicine and surgery, or podiatric medicine 342  
and surgery. 343

(4) "Prior authorization requirement" means any practice 344  
implemented by a medical assistance program in which coverage of 345  
a health care service or item is dependent upon a medical 346  
assistance recipient, or a health care provider, notifying the 347  
department of medicaid or its designee, including a medicaid 348  
managed care organization, that the service or item is going to 349  
be provided or requesting or receiving approval from the 350  
department or its designee. "Prior authorization" includes any 351  
precertification, notification, or referral program, or a 352  
prospective or utilization review conducted prior to providing a 353  
health care service or item. 354

(5) "Step therapy protocol" means a protocol or program 355  
that establishes the specific sequence in which a medical 356  
assistance recipient is to receive prescribed drugs to treat a 357  
specified medical condition that are medically appropriate for 358

that recipient. 359

(6) "Utilization review" and "utilization review organization" have the same meanings as in section 1751.77 of the Revised Code. 360  
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(B) If a medical assistance program has a prior authorization requirement, the department of medicaid or its designee, including a medicaid managed care organization, shall do all of the following: 363  
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(1) Use the prior authorization form adopted by the department under section 5160.33 of the Revised Code for all prior authorization requests or notifications made under the prior authorization requirement. 367  
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(2) Have the prior authorization requirement be based on clinical review criteria guidelines that are all of the following: 371  
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(a) Developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with the department or its designee or a utilization review organization that is conducting utilization review of the program; 374  
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(b) Based on high quality studies, research, and medical practice; 378  
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(c) Created by a transparent process that does all of the following: 380  
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(i) Minimizes biases and conflicts of interest; 382

(ii) Explains the relationship between treatment options and outcomes; 383  
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(iii) Rates the quality of the evidence supporting 385

<u>recommendations;</u>	386
<u>(iv) Considers relevant patient subgroups and preferences.</u>	387
<u>(d) Continuously updated through a review of new evidence</u> <u>and research.</u>	388 389
<u>(3) Beginning one year after the effective date of this</u> <u>section, permit a health care provider to access the prior</u> <u>authorization form through the provider's electronic software</u> <u>system.</u>	390 391 392 393
<u>(4) Beginning one year after the effective date of this</u> <u>section, permit the department or its designee to accept prior</u> <u>authorization forms through a secure electronic transmission.</u> <u>For purposes of division (B)(4) of this section, a facsimile is</u> <u>not considered a secure electronic transmission.</u>	394 395 396 397 398
<u>(5) Respond to all prior authorization requests within</u> <u>twenty-four hours for urgent health care needs, and forty-eight</u> <u>hours for all other health care needs, from the time the request</u> <u>is received by the department or its designee. If the department</u> <u>or its designee does not respond within the applicable time</u> <u>period, the request shall be automatically approved. Division</u> <u>(B)(5) of this section does not apply to emergency medical</u> <u>service or trauma care.</u>	399 400 401 402 403 404 405 406
<u>(6) Honor a prior authorization approval for an approved</u> <u>health care service or item for the lesser of the following from</u> <u>the date of approval:</u>	407 408 409
<u>(a) Twelve months;</u>	410
<u>(b) The last day of the medical assistance recipient's</u> <u>eligibility for the medical assistance program.</u>	411 412
<u>(7) Once the department or its designee has issued a prior</u>	413

authorization approval, not retroactively deny coverage for the 414  
approved health care service or item. 415

(8) Permit a prior authorization request to be amended 416  
within forty-eight hours of the rendering of a health care 417  
service or item approved through the prior authorization if the 418  
rendered service or item is different than the approved service 419  
or item. 420

(9) Ensure that an adverse prior authorization decision be 421  
made by either of the following: 422

(a) A physician or nurse under the direction of the 423  
department or its designee; 424

(b) A panel of appropriate health care reviewers if at 425  
least one member of the panel is a physician who is board 426  
certified or eligible to render the same specialty as the 427  
service or item under review. 428

(10) Disclose to all participating health care providers 429  
and medical assistance recipients any new prior authorization 430  
requirement at least sixty days prior to the effective date of 431  
the new requirement. 432

(11) Make available on the department's public web site 433  
all of the following information for each medical assistance 434  
program: 435

(a) A written description of any prior authorization 436  
requirements and statistics regarding prior authorization 437  
approvals and denials; 438

(b) The most recently published drug formulary for the 439  
public to view in one location covered prescribed drugs; 440

(c) Information on the program's tier structure for 441

covered prescribed drugs and the cost-sharing requirements for 442  
each tier; 443

(d) The drug utilization management system for each 444  
prescribed drug placed on the formulary, including prior 445  
authorization and step therapy protocol requirements and drug 446  
quantity limits; 447

(e) Cost-sharing requirements that apply to the program. 448

**Section 2.** That existing section 1739.05 of the Revised 449  
Code is hereby repealed. 450