

As Introduced

135th General Assembly

Regular Session

2023-2024

H. B. No. 359

Representative Young, T.

Cosponsors: Representatives Hillyer, Jones



A BILL

To amend section 3902.50 and to enact sections 1
5.22108, 3902.63, and 5164.093 of the Revised 2
Code to require health plan issuers and the 3
Medicaid program to cover treatments and 4
services related to Pediatric Autoimmune 5
Neuropsychiatric Disorders Associated with 6
Streptococcal Infections and Pediatric Acute- 7
onset Neuropsychiatric Syndrome. 8

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

Section 1. That section 3902.50 be amended and sections 9
5.22108, 3902.63, and 5164.093 of the Revised Code be enacted to 10
read as follows: 11

Sec. 5.22108. The ninth day of October shall be designated 12
"PANDAS and PANS Awareness Day," referring to pediatric 13
autoimmune neuropsychiatric disorders associated with 14
streptococcal infections, commonly referred to as PANDAS, and 15
pediatric acute-onset neuropsychiatric syndrome, commonly 16
referred to as PANS. 17

Sec. 3902.50. As used in sections 3902.50 to 3902.72 of 18

the Revised Code:	19
(A) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.	20 21
(B) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.	22 23
(C) "Cost sharing" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirement.	24 25 26 27
(D) "Covered" or "coverage" means the provision of benefits related to health care services to a covered person in accordance with a health benefit plan.	28 29 30
(E) "Covered person," "health benefit plan," "health care services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.	31 32 33
(F) "Drug" has the same meaning as in section 4729.01 of the Revised Code.	34 35
(G) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.	36 37
(H) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:	38 39
(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;	40 41
(2) Treatment necessary to stabilize an emergency medical condition;	42 43
(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.	44 45

(I) "Health care practitioner" has the same meaning as in 46
section 3701.74 of the Revised Code. 47

(J) "Pharmacy benefit manager" has the same meaning as in 48
section 3959.01 of the Revised Code. 49

(K) "Prior authorization requirement" means any practice 50
implemented by a health plan issuer in which coverage of a 51
health care service, device, or drug is dependent upon a covered 52
person or a provider obtaining approval from the health plan 53
issuer prior to the service, device, or drug being performed, 54
received, or prescribed, as applicable. "Prior authorization 55
requirement" includes prospective or utilization review 56
procedures conducted prior to providing a health care service, 57
device, or drug. 58

(L) "Step therapy protocol" has the same meaning as in 59
section 3901.83 of the Revised Code. 60

(M) "Unanticipated out-of-network care" means health care 61
services, including clinical laboratory services, that are 62
covered under a health benefit plan and that are provided by an 63
out-of-network provider when either of the following conditions 64
applies: 65

(1) The covered person did not have the ability to request 66
such services from an in-network provider. 67

(2) The services provided were emergency services. 68

Sec. 3902.63. (A) As used in this section, "diagnostic 69
evaluation" includes all testing and services appropriate for 70
any class of medical, neurological, or immune-mediated 71
disorders, including autoimmune encephalitis. 72

(B) Notwithstanding section 3901.71 of the Revised Code, a 73

health benefit plan issued, delivered, or renewed on or after 74
the effective date of this section shall provide coverage for 75
the screening, diagnosis, and treatment of pediatric autoimmune 76
neuropsychiatric disorders associated with streptococcal 77
infections, commonly referred to as PANDAS, and pediatric acute 78
onset neuropsychiatric syndrome, commonly referred to as PANS. 79

(C) A health plan issuer shall not apply a cost-sharing 80
requirement to the coverage required under division (B) of this 81
section that is less favorable than the cost-sharing requirement 82
that applies substantially to all medical and surgical benefits 83
provided under the health benefit plan. 84

(D) Benefits required under division (B) of this section 85
shall cover, at minimum, all of the following: 86

(1) Comprehensive diagnostic evaluation, symptomatic 87
relief, and related services, including laboratory, radiology, 88
psychiatric, and behavioral services; 89

(2) Immunomodulatory therapies, including all of the 90
following: 91

(a) Immunoglobulin therapy, including both high dose and 92
low dose infusions, as well as the cost of related medications, 93
administration, and monitoring; 94

(b) Corticosteroids; 95

(c) Plasmapheresis; 96

(d) Rituxmab or similar products. 97

(3) Antimicrobial treatment, including antibiotics and 98
antivirals; 99

(4) Therapeutic care, including services provided by a 100

speech therapist, speech-language pathologist, occupational 101
therapist, or physical therapist licensed or certified in the 102
state in which the therapist practices. 103

(E)(1) The coverage required under division (B) of this 104
section shall not be subject to either a step therapy protocol 105
or a prior authorization requirement. 106

(2) The coverage required under division (B) of this 107
section shall not be contingent upon either of the following: 108

(a) A patient's symptoms meeting a specified threshold of 109
severity; 110

(b) A patient having a specified immunodeficiency status. 111

(F) If, at any time, this state is required to defray the 112
cost of any coverage required under division (B) of this 113
section, pursuant to any provision of the "Patient Protection 114
and Affordable Care Act of 2010," Pub. L. No. 111-148, including 115
42 U.S.C. 18031(d) (3) (B), or any successor provision, or 116
pursuant to any rules or regulations promulgated, or any 117
opinion, guidance, or other action made, by the secretary of the 118
United States department of health and human services, or its 119
successor agency, then the requirement made under division (B) 120
of this section shall be inoperative, other than any such 121
coverage authorized under 42 U.S.C. 1396a, and the state shall 122
not assume any obligation for the cost of coverage required 123
under division (B) of this section. 124

Sec. 5164.093. (A) As used in this section: 125

(1) "Diagnostic evaluation" includes all testing and 126
services appropriate for any class of medical, neurological, or 127
immune-mediated disorders, including autoimmune encephalitis. 128

<u>(2) "Prior authorization requirement" has the same meaning</u>	129
<u>as in section 5160.34 of the Revised Code.</u>	130
<u>(3) "Step therapy protocol" has the same meaning as in</u>	131
<u>section 5164.7512 of the Revised Code.</u>	132
<u>(B) The medicaid program shall provide coverage for the</u>	133
<u>screening, diagnosis, and treatment of pediatric autoimmune</u>	134
<u>neuropsychiatric disorders associated with streptococcal</u>	135
<u>infections, commonly referred to as PANDAS, and pediatric acute-</u>	136
<u>onset neuropsychiatric syndrome, commonly referred to as PANS.</u>	137
<u>(C) The medicaid program shall not institute a cost-</u>	138
<u>sharing requirement under section 5162.20 of the Revised Code to</u>	139
<u>the coverage required under division (B) of this section that is</u>	140
<u>less favorable than the cost-sharing requirement that applies</u>	141
<u>substantially to all medical and surgical benefits provided</u>	142
<u>under the health benefit plan.</u>	143
<u>(D) Benefits required under division (B) of this section</u>	144
<u>shall cover, at a minimum, all of the following:</u>	145
<u>(1) Comprehensive diagnostic evaluation, symptomatic</u>	146
<u>relief, and related services, including laboratory, radiology,</u>	147
<u>psychiatric, and behavioral services;</u>	148
<u>(2) Immunomodulatory therapies, including all of the</u>	149
<u>following:</u>	150
<u>(a) Immunoglobulin therapy, including both high dose and</u>	151
<u>low dose infusions, as well as the cost of related medications,</u>	152
<u>administration, and monitoring;</u>	153
<u>(b) Corticosteroids;</u>	154
<u>(c) Plasmapheresis;</u>	155

<u>(d) Rituxmab or similar products.</u>	156
<u>(3) Antimicrobial treatment, including antibiotics and antivirals;</u>	157 158
<u>(4) Therapeutic care, including services provided by a speech therapist, speech-language pathologist, occupational therapist, or physical therapist licensed or certified in the state in which the therapist practices.</u>	159 160 161 162
<u>(E) (1) The coverage required under division (B) of this section shall not be subject to either a step therapy protocol or a prior authorization requirement.</u>	163 164 165
<u>(2) The coverage required under division (B) of this section shall not be contingent upon either of the following:</u>	166 167
<u>(a) A patient's symptoms meeting a specified threshold of severity;</u>	168 169
<u>(b) A patient having a specified immunodeficiency status.</u>	170
<u>(F) If, at any time, this state is required to defray the cost of any coverage required under division (B) of this section, pursuant to any provision of the "Patient Protection and Affordable Care Act of 2010," Pub. L. No. 111-148, including 42 U.S.C. 18031(d) (3) (B), or any successor provision, or pursuant to any rules or regulations promulgated, or any opinion, guidance, or other action made, by the secretary of the United States department of health and human services, or its successor agency, then the requirement made under division (B) of this section shall be inoperative, other than any such coverage authorized under 42 U.S.C. 1396a, and the state shall not assume any obligation for the cost of coverage required under division (B) of this section.</u>	171 172 173 174 175 176 177 178 179 180 181 182 183

Section 2. That existing section 3902.50 of the Revised Code is hereby repealed.

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