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Sponsor Testimony House Bill 220

House Insurance Committee

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Chairman Lampton, Vice Chair Craig, Ranking Member Tims, and members of the House Insurance Committee — thank you for the opportunity to offer sponsor testimony on House Bill 220.

This bill takes important steps to reform the increasingly broken prior authorization system that continues to put bureaucratic obstacles between Ohioans and the care their physicians and health care providers know they need. This legislation does not get rid of the prior authorization process, nor does it remove prior authorization requirements, it simple clarifies certain prior authorization statutes already in Ohio law. — it simply clarifies certain prior authorization statutes already in Ohio law.

House Bill 220 makes four critical updates:

1. It tightens Ohio's retroactive denial law to ensure that once a prior authorization is approved and the care is delivered, insurers cannot later deny payment.
2. It strengthens peer-to-peer review standards so that only appropriately credentialed physicians — in the same specialty — can conduct reviews and must respond promptly.
3. It ensures that dosage adjustments for chronic disease medications do not invalidate a 12-month prior authorization, keeping patients on a steady course of treatment without unnecessary interruptions.
4. It prohibits health plans from charging providers for appealing a denial, ending an emerging practice that penalizes clinicians for simply trying to secure fair reimbursement and appropriate care for their patients.

Let me start with the human cost. Nearly 7 million Ohioans live with at least one chronic disease. These conditions don't come with one-size-fits-all solutions. Physicians often need to adjust a patient's medication dosage based on how they're responding. But some insurance companies treat a simple dose adjustment — even one that's lower in cost — as an entirely new treatment, triggering another prior authorization process. This makes no sense. It causes delays, adds paperwork, and can force patients to either endure unsafe alternatives or deteriorate while they wait.

House Bill 220 fixes that. It clarifies that dose adjustments within the same treatment should not require an entirely new round of prior authorization. It builds upon already existing laws in Ohio that allow a prior authorization to be valid for an entire year if it is for a drug for a patient who has been diagnosed with a chronic condition. This modification to now allow for dose adjustments within that year time period helps ensure patients get the medication they need, when they need it — not when the insurer gets around to it.

And there's more. House Bill 220 also strengthens peer-to-peer reviews — the mechanism by which providers appeal insurance denials. Right now, providers often spend hours trying to justify care decisions to insurance reviewers who are not even in the same specialty. Imagine being a neurologist and having to defend brain surgery to an OB-GYN working for a health plan. It happens — and it's unacceptable.

According to the American Medical Association, only 16% of physicians say these "peers" often or always have the proper clinical qualifications. That's not peer review — that's delay by design.

House Bill 220 would require that peer reviewers actually practice in the same specialty and have training relevant to the case at hand. It would also set a clear timeframe for making these determinations, so patient care doesn't hang in limbo.

This bill also seeks to clarify the existing law around what insurers call "retroactive reviews/denials." Imagine being a provider, jumping through all the hoops a health plan requires in order to get a prior authorization approved for a specific test, drug or surgery. But, after providing the heath care service, the insurer does a retroactive review and then denies payment for the service they previously approved. We would never see an issue like this in any other industry, yet in healthcare, providers experience this every day. My bill simply addresses this by clarifying, if you get a prior authorization approved, it cannot be denied on the back end.

Finally, House Bill 220 puts an end to an alarming new practice — insurers charging providers fees for appealing denied claims. In no other professional setting is someone expected to pay to challenge a rejection of payment for work they've already done. This bill makes clear that if a provider is forced to appeal a denial, they cannot be financially penalized for doing so.

In total, this legislation aims to address a broader trend. Insurers are rolling out new systems and policies that increase documentation requirements, penalize providers for appealing denials, and squeeze physician practices with administrative burden. According to the AMA, 93% of physicians report care delays due to prior authorization — and nearly 1 in 3 say that criteria used to approve care aren't even evidence-based.

Providers and facilities cannot keep up with the impossible demands coming from massive over regulation directly by insurance companies. This isn't just a provider burnout issue — although that's real. This is about patients losing access to care, missing work, or even suffering permanent harm due to unnecessary red tape.

House Bill 220 is about putting doctors, providers, and patients back at the center of health care. It restores common sense to the process and ensures medical decisions are made based on evidence and clinical judgment — not profit models.

I want to thank the many stakeholders — physicians, hospitals, and patients — who have helped shape this legislation.

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I respectfully urge the committee to support House Bill 220 and I'd be happy to answer any questions from the committee.

Thank you,

State Representative Heidi Workman