

**As Introduced**

**136th General Assembly  
Regular Session  
2025-2026**

**H. B. No. 831**

**Representative Daniels  
Cosponsor: Representative Young**

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To amend section 3902.50 and to enact sections 1  
5.22108, 3902.65, and 5164.094 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, 3902.65, and 5164.094 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. 3902.65.** (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. 5164.094.** (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

(2) "Prior authorization requirement" has the same meaning 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

(3) Antimicrobial treatment, including antibiotics and 157  
antivirals; 158

(4) Therapeutic care, including services provided by a 159  
speech therapist, speech-language pathologist, occupational 160  
therapist, or physical therapist licensed or certified in the 161  
state in which the therapist practices. 162

(E) (1) The coverage required under division (B) of this 163  
section shall not be subject to either a step therapy protocol 164  
or a prior authorization requirement. 165

(2) The coverage required under division (B) of this 166  
section shall not be contingent upon either of the following: 167

(a) A patient's symptoms meeting a specified threshold of 168  
severity; 169

(b) A patient having a specified immunodeficiency status. 170

(F) If, at any time, this state is required to defray the 171  
cost of any coverage required under division (B) of this 172  
section, pursuant to any provision of the "Patient Protection 173  
and Affordable Care Act of 2010," Pub. L. No. 111-148, including 174  
42 U.S.C. 18031(d)(3)(B), or any successor provision, or 175  
pursuant to any rules or regulations promulgated, or any 176  
opinion, guidance, or other action made, by the secretary of the 177  
United States department of health and human services, or its 178  
successor agency, then the requirement made under division (B) 179  
of this section shall be inoperative, other than any such 180  
coverage authorized under 42 U.S.C. 1396a, and the state shall 181  
not assume any obligation for the cost of coverage required 182  
under division (B) of this section. 183

**Section 2.** That existing section 3902.50 of the Revised 184  
Code is hereby repealed. 185