As Introduced

136th General Assembly
Regular Session
2025-2026

H. B. No. 831

Representative Daniels
Cosponsor: Representative Young

To amend section 3902.50 and to enact sections 5.22108, 3902.65, and 5164.094 of the Revised Code to require health plan issuers and the Medicaid program to cover treatments and services related to Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome.

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

Section 1. That section 3902.50 be amended and sections 5.22108, 3902.65, and 5164.094 of the Revised Code be enacted to read as follows:

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

Sec. 3902.50. As used in sections 3902.50 to 3902.72 of the Revised Code:

(A) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.

(B) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.

(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.

(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.

(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.

(F) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

(G) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.

(H) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(2) Treatment necessary to stabilize an emergency medical condition;

(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(I) "Health care practitioner" has the same meaning as in

section 3701.74 of the Revised Code.

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

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

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

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

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

(2) The services provided were emergency services.

Sec. 3902.65. (A) As used in this section, "diagnostic evaluation" includes all testing and services appropriate for any class of medical, neurological, or immune-mediated disorders, including autoimmune encephalitis.

(B) Notwithstanding section 3901.71 of the Revised Code, a health benefit plan issued, delivered, or renewed on or after

the effective date of this section shall provide coverage for the screening, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, commonly referred to as PANDAS, and pediatric acute onset neuropsychiatric syndrome, commonly referred to as PANS.

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

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

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

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

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

(b) Corticosteroids;

(c) Plasmapheresis;

(d) Rituxmab or similar products.

(3) Antimicrobial treatment, including antibiotics and antivirals;

(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.

(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.

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

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

(b) A patient having a specified immunodeficiency status.

(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.

Sec. 5164.094. (A) As used in this section:

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

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

as in section 5160.34 of the Revised Code.

(3) "Step therapy protocol" has the same meaning as in section 5164.7512 of the Revised Code.

(B) The medicaid program shall provide coverage for the screening, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, commonly referred to as PANDAS, and pediatric acute-onset neuropsychiatric syndrome, commonly referred to as PANS.

(C) The medicaid program shall not institute a cost-sharing requirement under section 5162.20 of the Revised Code to the coverage required under division (B) of this section that is less favorable than the cost-sharing requirement that applies substantially to all medical and surgical benefits provided under the health benefit plan.

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

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

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

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

(b) Corticosteroids;

(c) Plasmapheresis;

(d) Rituxmab or similar products.

(3) Antimicrobial treatment, including antibiotics and antivirals;

(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.

(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.

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

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

(b) A patient having a specified immunodeficiency status.

(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.

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