As Introduced

131st General Assembly
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S. B. No. 129

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

A BILL

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

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

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

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

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

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

(3) The arrangement has and maintains a minimum enrollment

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

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

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

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

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

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

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

same meanings as in section 4765.01 of the Revised Code.

(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.

(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.

(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.

(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.

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

(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

following:

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

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

(a) Developed and endorsed by an independent, multidisciplinary panel of experts not affiliated with the health insuring corporation or a utilization review organization that is conducting utilization review of the health insuring corporation;

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

(c) Created by a transparent process that does all of the following:

(i) Minimizes biases and conflicts of interest;

(ii) Explains the relationship between treatment options and outcomes;

(iii) Rates the quality of the evidence supporting recommendations;

(iv) Considers relevant patient subgroups and preferences.

(d) Continuously updated through a review of new evidence and research.

(3) Beginning one year after the effective date of this section, permit medical providers to access the prior

authorization form through the provider's electronic software system.

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

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

(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:

(a) Twelve months;

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

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

(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.

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

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

(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.

(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.

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

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

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

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

(d) The drug utilization management system for each drug

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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.

(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.

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

(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 policy of sickness and accident insurance or a public employee benefit plan.

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

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

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

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

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

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

(c) Created by a transparent process that does all of the following:

(i) Minimizes biases and conflicts of interest;

(ii) Explains the relationship between treatment options and outcomes;

(iii) Rates the quality of the evidence supporting recommendations;

(iv) Considers relevant patient subgroups and preferences.

(d) Continuously updated through a review of new evidence and research.

(3) Beginning one year after the effective date of this section, permit medical providers to access the prior authorization form through the provider's electronic software system.

(4) Beginning one year after the effective date of this section, permit the policy or plan, a pharmacy benefit manager responsible for handling prior authorization requests, or other payer to accept prior authorization forms through a secure electronic transmission. For purposes of division (B)(4) of this section, a facsimile is not considered a secure electronic transmission.

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

(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:

(a) Twelve months;

(b) The last day of the covered person's eligibility under the policy or plan.

(7) Once an insurer or plan has issued a prior authorization approval, not retroactively deny coverage for the approved medical service or drug.

(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.

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

(a) A physician or nurse under the direction of the director of the insurer or plan;

(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.

(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.

(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

before the individual enrolls in a policy or plan and shall include all of the following:

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

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

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

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

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

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

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

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

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

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

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

(2) "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.

(3) "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.

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

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

that recipient.

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

(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:

(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.

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

(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;

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

(c) Created by a transparent process that does all of the following:

(i) Minimizes biases and conflicts of interest;

(ii) Explains the relationship between treatment options and outcomes;

(iii) Rates the quality of the evidence supporting

recommendations;

(iv) Considers relevant patient subgroups and preferences.

(d) Continuously updated through a review of new evidence and research.

(3) Beginning one year after the effective date of this section, permit a health care provider to access the prior authorization form through the provider's electronic software system.

(4) Beginning one year after the effective date of this section, permit the department or its designee to accept prior authorization forms through a secure electronic transmission. For purposes of division (B)(4) of this section, a facsimile is not considered a secure electronic transmission.

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

(6) Honor a prior authorization approval for an approved health care service or item for the lesser of the following from the date of approval:

(a) Twelve months;

(b) The last day of the medical assistance recipient's eligibility for the medical assistance program.

(7) Once the department or its designee has issued a prior

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

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

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

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

(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 service or item under review.

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

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

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

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

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

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

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

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

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