Ohio Legislative Service Commission

Bill Analysis

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Sub. S.B. 129*

131st General Assembly
(As Reported by S. Insurance)

Sens. Gardner and Cafaro, Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner

BILL SUMMARY

- Adopts criteria in relation to health insurance prior authorization requirements.
- Imposes prior authorization request response deadlines on health plan issuers.
- Requires health plan issuers to honor prior authorizations for specified time periods.
- Specifies, for health plan issuers not related to DOM, that violations of the bill's requirements are considered unfair and deceptive practices.

CONTENT AND OPERATION

Overview

The bill adopts criteria in relation to health insurance prior authorization requirements. Under the bill, a prior authorization requirement is any notification or approval requirement upon which coverage of a service, drug, or device is dependent. The bill applies to health insuring corporations, sickness and accident insurers, public employee benefit plans, multiple employer welfare corporations, and the Department of Medicaid (DOM), all of which are collectively referred to as health plan issuers in this analysis.[1] The bill's Medicaid provisions use slightly different terminology that have been adapted for a simpler explanation of the bill.

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* This analysis was prepared before the report of the Senate Insurance Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

[1] R.C. 1739.05, 1751.72, 3901.90, 3923.041, 5160.33, and 5160.34.

The bill adopts various effective dates for each of its provisions. The effective date for each provision is noted below.

Prior authorization requests submitted via electronic system

Under the bill, health plan issuers are required to permit health care practitioners to access prior authorization forms through the applicable software system. It is unclear exactly to what "applicable software system" refers. Similarly, a health plan issuer, or other payer acting on behalf of the issuer, must accept prior authorization request through a secure electronic transmission. For prescription requests, the health plan issuer must use NCPDP SCRIPT standard ePA transactions. For prior medical benefit authorization requests, the health plan issuer must use standards established by the Council for Affordable Quality Health Care on Operating Rules for Information Exchange. Neither a proprietary payer portal that does not use NCPDP SCRIPT standard nor a facsimile or any sort are considered a secure electronic transmission.

Note, however, that the bill authorizes a health care practitioner and a health plan issuer to enter into a contract under which the health insuring corporation agrees to process prior authorization request that are not submitted electronically because of the financial hardship or if Internet access is restricted where the practitioner is located.

The effective date of these provisions is January 1, 2018.[2]

Response deadlines

Under the bill, a health plan issuer must respond to prior authorization requests in a timely manner. For urgent care services, the health plan issuer must respond within one business day from the time the request is received by the health plan issuer. For any prior authorization that is not related to an urgent care service, the deadline is five business days. These deadlines do not apply to emergency medical services or trauma care. The bill requires that such a response indicate whether an approval request is approved, denied, or requires more information. If the response is denied, the issuer must provide the specific reason for the denial. If the request is considered incomplete, the issuer must identify the additional information that is required. For an incomplete request, after all required information has been submitted, the health plan issuer must issue a response according to the timelines above. Finally, a health plan issuer must issue a receipt acknowledging a prior authorization request has been received.

The effective date of these provisions is January 1, 2018.[3]

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[2] R.C. 1751.72(B)(1) to (3), 3923.041(B)(1) to (3), and 5160.34(B)(1) to (3).

[3] R.C. 1751.72(B)(4) and (5), 3923.041(B)(4) and (5), and 5160.34(B)(4) and (5).

Honoring prior authorization approvals

The bill requires health plan issuers, for a prior approval related to a chronic condition, to honor a prior authorization request for a drug for the lesser of the following:

- Twelve months from the date of the approval;
- The last day of the covered person in question's eligibility under the health plan.

The duration for all other prior authorization requests are to be governed by the relevant health plan. Additionally, a health plan issuer may require a health care practitioner to submit information indicating that the patient's chronic condition has not changed. A health plan issuer can ask for this information no earlier than six months, but no later than seven months, after the initial prior approval request was submitted. Additionally, a 12-month prior approval is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance prescribing that the drug in question is no longer approved or safe for the intended purpose.[4]

The bill makes certain exclusions to the 12-month approval period. A health plan issuer is not required to provide a 12-month approval for a drug that meets all of the following characteristics:

- The drug is prescribed for an individual with a complex or rare medical condition.
- The drug costs $600 or more for up to a 30-day supply.
- The drug is not typically stocked at retail pharmacies.
- The drug requires difficult or unusual delivery, preparation, or handling of the drug, or it requires enhanced patient education, management, or support.[5]

The bill also stipulates that a health plan issuer is not required to provide the 12-month approval for a drug that has a typical treatment plan of less than one year.[6]

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[4] R.C. 1751.72(B)(6), 3923.041(B)(6), and 5160.34(B)(6).

[5] R.C. 1751.72(B)(7), 3923.041(B)(7), and 5160.34(B)(7).

[6] R.C. 1751.72(B)(8), 3923.041(B)(8), and 5160.34(B)(8).

The effective date of these provisions is January 1, 2017.[7]

Retrospective review

The bill requires a health plan issuer, upon written request, to conduct a retrospective review for a claim that is submitted for a service where prior authorization was originally required, but not obtained, if the service in question meets all of the following characteristics:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

Once the written request and all necessary information is received, the health plan issuer is required to review the claim for coverage and medical necessity. The health plan issuer shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

The effective date of these provisions is January 1, 2017.[8]

Health benefit product information accessibility

The bill requires a health plan issuer to disclose to all participating health care practitioners any new prior authorization requirements at least 30 days prior to the effective date of the changes. The notice may be sent via electronic mail or standard mail and is to be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but must include specific information on where the health care practitioner may locate the information on the health plan issuer's website or, if applicable, the health plan issuer's portal. The effective date of this provision is January 1, 2017.[9]

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[7] R.C. 1751.72(B)(6), (7), and (8), 3923.041(B)(6), (7), and (8), and 5160.34(B)(6), (7), and (8).

[8] R.C. 1751.72(B)(9), 3923.041(B)(9), and 5160.34(B)(9).

[9] R.C. 1751.72(B)(10), 3923.041(B)(10), and 5160.34(B)(10).

A health plan issuer that uses prior authorization requirements must make available on its website or provider portal a list of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete. The health plan issuer must also make available on its website information about the policies, contracts, or agreements offered by the health plan issuer that clearly identifies specific services, drugs, or devices to which a prior authorization requirement exists. The effective date of this provision is January 1, 2017.[10]

Appeal process

The bill requires a health plan issuer to establish a streamlined reconsideration and appeal process relating to prior approval denials. For urgent care services, a health plan issuer must conduct the reconsideration within one business day after the health plan issuer receives the request for reconsideration. For any prior approval request that is not for an urgent care service, the reconsideration must occur within two business days after the health plan issuer receives the request for reconsideration. The reconsideration is to be conducted between the health care practitioner and the reviewer who made the adverse determination. If the reviewer cannot be available in accordance with these timeframes, the reviewer is to designate another reviewer. If the health care practitioner cannot be available for the reconsideration, the health care practitioner may designate another health care practitioner.

If the reconsideration does not resolve the disagreement, the health care practitioner may appeal the adverse determination. For urgent care services, the appeal is to be heard within one business day after the health plan issuer receives the appeal. For all other matters, the appeal is to be heard within five business days after the health plan issuer receives the appeal. The appeal is to be between the health care practitioner requesting the service in question and a clinical peer. If the appeal does not resolve the disagreement, then either the health care practitioner or the covered person may request an external review under the relevant law.

The effective date of this provision is January 1, 2018.[11]

Prior authorization determinations binding

Under the bill, except in cases of fraudulent or materially incorrect information, prior determinations relation to benefit coverage and medical necessity are binding on the health plan issuer if obtained not more than 60 days prior to the date the service,

[10] R.C. 1751.72(B)(11), 3923.041(B)(11), and 5160.34(B)(11).

[11] R.C. 1751.72(B)(12), 3923.041(B)(12), and 5160.34(B)(12).

drug, or device is provided or received. The health plan issuer is not required to provide such coverage for a service, drug, or device if, due to the covered individual switching health plans, the service, drug, or device is no longer considered a covered service, drug, or device at the time the service, drug, or device is provided.

The effective date of this provision is January 1, 2017.[12]

Prohibited requirements

The bill prohibits a health plan issuer from imposing a restriction or condition in relation to prior authorization determinations that limits, restricts, or effectively eliminates the binding force of determinations made in accordance with the bill.

The effective date of this provision is January 1, 2017.[13]

Unfair and deceptive practice

With regard to health plan issuers that are not related to DOM, committing a series of violation of these requirements that, taken together, constitute a practice or pattern is considered an unfair and deceptive practice. Continuing law unchanged by the bill enables the Superintendent to conduct a hearing to determine if an unfair or deceptive practice has occurred. If, subsequent to the hearing, the Superintendent determines that an insurer has engaged in an unfair or deceptive practice, then the Superintendent is required to issue a cease and desist order. Additionally, the Superintendent may suspend the violator's license, require the termination of the employment of the person responsible for the violation, or issue a fine or other possible sanctions.

The effective date of this provision is January 1, 2017.[14]

Definitions

The bill defines the following terms:

"Chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

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[12] R.C. 1751.72(C), 3923.041(C), and 5160.34(C).

[13] R.C. 1751.72(D), 3923.041(D), and 5160.34(D).

[14] R.C. 1751.72(E) and 3923.041(E) and R.C. 3964.05(B) and R.C. 3901.22(A), not in the bill.

"Clinical peer" means a health care practitioner in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

"Covered person" means a person receiving coverage for health services under a health benefit product issued by a health plan issuer.

"Emergency medical service" means medical services performed by first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, and paramedics. The term includes services performed before or during any transport of a patient, including transports between hospitals and transports to and from helicopters.

"Fraudulent or materially incorrect information" means any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the covered person in question.

"Health care practitioner" means a dentist or dental hygienist, a nurse, an optometrist, an optician, a pharmacist, a physician, a physician's assistant, a psychologist, a chiropractor, a hearing aid dealer, a speech-language pathologist or audiologist, an occupational therapist, a physical therapist, a professional counselor or social worker, a dietician, a respiratory care professional, or an emergency care professional.

"NCPDP SCRIPT standard" means the national council for prescription drug programs SCRIPT standard version 201310 or the most recent standard adopted by the United States Department of Health and Human Services.

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

"Trauma care" means the assessment, diagnosis, transportation, treatment or rehabilitation of a trauma victim by emergency medical service personnel or by a physician, nurse, physician assistant, respiratory therapist, physical therapist, chiropractor, occupational therapist, speech-language pathologist, audiologist, or psychologist licensed to practice as such in Ohio or another jurisdiction.

"Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

"Utilization review organization" means an entity that conducts utilization reviews, other than a health plan issuer performing a review of its own health benefit products.[15]

HISTORY

ACTION	DATE
Introduced	03-16-15
Reported, S. Insurance	12-09-15

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[15] R.C. 1751.72(A), 3923.041(A), and 5160.34(A).