PRIOR AUTHORIZATION PROPOSAL PASSES GENERAL ASSEMBLY

Ohio State Medical Association

New rules for a more transparent, efficient & fair process on the way!

This legislation aims to simplify and expedite the process of obtaining prior authorization, reduce much of the associated hassles and burdens for all parties involved, and improve patient access to critical treatments and procedures.

The OSMA's prior authorization reform legislation, Senate Bill 129, passed unanimously through the Ohio Senate and the Ohio House and was signed into law by Governor John Kasich.

During the year-long debate on the bill, the health insurance industry fiercely lobbied against the measure. There were countless "interested party" meetings where literally every word in the proposed law was debated. The insurance industry called the bill "the most comprehensive health insurance reform law in the country" and, as a result, they marshalled considerable resources to try and water-down the bill. While the OSMA had to make some concessions from the original introduced version of the bill, at the end of the day all of the major provisions stayed intact.

Because the legislation was so comprehensive, there are different elements that will become fully effective at different times. This is because insurers usually file their proposed premium rates with the Ohio Department of Insurance in early summer for policies that are sold at the beginning of the next year. Insurers also claimed they needed additional time to develop new information technology software and to ramp up potential staffing to comply with the various provisions.

Main provisions effective in January 2017:

1. **Insurers must disclose all PA rules to participating providers, including specific information or documentation that a provider must submit in order for the PA request to be considered complete.**
2. **Insurers must disclose to all participating providers all new prior authorization requirements at least 30 days prior to the effective date of the new requirement.**
3. **Enrollees of the health plan must receive basic information about which drugs and services will require prior authorization.**
4. **A provision prohibiting retroactive denials when, on the date the provider renders the prior approved service:**
    - *The patient is eligible;*
    - *The patient's condition hasn't changed;*
    - *The provider submits an accurate claim that matches the information submitted by the provider in the approved PA request.*
5. **A provision allowing a retrospective review of a claim where a PA was required but not obtained when the service in question meets all of the following:**
    - *The service is related to another service for which a PA has already been obtained and has already been performed;*
    - *The 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.*
6. **Insurers must allow for a 12-month PA for medications to treat a chronic disease under certain circumstances.**

SB 129

NOTE: If you are experiencing an issue with a payer not complying with the enacted provisions of the law, you can file a complaint with the Ohio Department of Insurance.

Find the form at: OSMA.org/ProviderComplaintForm

Main provisions effective in January 2018:

1. **Insurers must have a web-based system through which to receive prior authorization (PA) requests:**
   - *For prescription benefits, the system shall accept and respond to PA requests through a secure electronic transmission using NCPDP SCRIPT standard ePA transactions.*
   - *For medical benefits, the system shall accept and respond to PA requests through a secure electronic transmission using standards established by the Council of Affordable Quality Health Care (CAQH) for information exchange.*
2. **Faster turnaround times for a PA requests:**
   - *For urgent situations, the insurer shall approve or deny the PA request within 48 hours.*
   - *Urgent situations are those where a delay in patient care could seriously jeopardize the life, health or safety of the patient or, in the opinion of the practitioner with knowledge of the patient's condition, a delay would subject the patient to adverse health consequences without the care that is subject of the request.*
   - *For non-urgent situations, the insurer shall approve or deny the PA request within 10 calendar days.*
3. **More clarity when an insurer responds to a PA request:**
   - *The insurer must provide an electronic receipt to the provider acknowledging that the PA request was received;*
   - *If the PA is denied, the insurer must provide the specific reason for the denial;*
   - *If the PA request is incomplete, the insurer shall indicate the specific additional information that is required to process the request.*
4. **Faster turnaround times for PA appeals:**
   - *For urgent care services, appeals must be considered within 48-hours after the insurer receives the appeal;*
   - *For non-urgent services, appeals must be considered within 10 calendar days after the insurer receives the appeal;*
   - *All appeals shall be between the health care provider requesting the service and a "clinical peer" within the insurer's internal utilization review operation. A clinical peer is a provider in the same, or similar, specialty that typically manages the medical condition under review.*
   - *If the internal appeal does not resolve the disagreement, either the patient or an authorized representative may request an external appeal, which is decided by a neutral, independent medical expert not associated with the insurer.*

Other Important Components:

Another important component of SB 129 is a provision that prohibits an insurer from imposing in their provider contracts any provision that is contrary to the protections afforded in the bill. Additionally, the bill will apply broadly to health insuring corporations, sickness and accident insurers as well as the Medicaid managed care plans (the law will not apply to ERISA self-insured plans or Medicare advantage plans because the federal government has exclusive jurisdiction over those plans).

SB 129 was developed by the OSMA and was introduced into the legislature by state Senator Randy Gardner (R-Bowling Green) and state Senator Capri Cafaro (D- Hubbard). Without their commitment and perseverance, this bill would not have passed. Nor would the bill have passed without the help of the OSMA developed broad-based coalition to support the bill, representing more than 80 provider and patient advocacy organizations.

After months of testimony, debate, and negotiations, prior authorization reform is a reality in Ohio. We have built a foundation for a PA system that will be more transparent, more efficient and more fair. As a result, the PA process for submitting requests, obtaining responses and approvals, and working through appeals will become more streamlined. This victory eases significant financial and administrative burden on Ohio medical professionals and practices, giving them more time and resources to focus on providing the best care for their patients.