As Introduced

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Senator Cafaro

Cosponsors: Senators Brown, Smith

A B I L L

To amend section 1739.05 and to enact sections 1751.72, 3901.90, 3923.251, and 5160.33 of the Revised Code to amend the law related to the prior authorization requirements of insurers and of the medical assistance programs administered by the Department of Medicaid.

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, 3923.251, and 5160.33 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, 3923.24, 3923.251, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 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" has the same meaning as in section 3901.90 of the Revised Code.

(2) "Prior authorization requirement" means any practice implemented by a health insuring corporation in which coverage of a health care service is dependent upon a covered person, or a

health care provider, notifying the health insuring corporation that the service is going to be provided or requesting and 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.

(3) "Utilization review" has the same meaning 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 comply with both of the following:

(1) The health insuring corporation shall use the prior authorization form adopted in rule 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) If the prior authorization requirement stipulates that the health insuring corporation must either respond to a request for coverage or approve or deny a request for coverage, then the health insuring corporation shall either respond to the request or deny or authorize the request, as appropriate, within forty-eight hours after the health insuring corporation receives the form.

(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 is dependent upon a covered person, or a health care provider, notifying the health plan issuer that the service is going to be provided or requesting and 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 in rule a standard form by which a covered person may request prior authorization under a prior authorization requirement.

Sec. 3923.251. (A) As used in this section:

(1) "Covered person" has the same meaning as in section 3901.90 of the Revised Code.

(2) "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 is dependent upon a covered person, or the health care provider, notifying the insurer or plan that the service is going to be provided or requesting and receiving approval from the insurer or plan. "Prior authorization requirement" includes any precertification, notification, or referral program, or a prospective or utilization review conducted prior to providing a health care service.

(3) "Utilization review" has the same meaning 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 comply with both of the following:

(1) The insurer or plan shall use the prior authorization form adopted in rule by the superintendent of insurance under section 3901.90 of the Revised Code for all prior authorization notifications or requests made under a prior authorization requirement.

(2) If the prior authorization requirement stipulates that the insurer or plan must either respond to a request for coverage or approve or deny a request for coverage, then the insurer or plan shall either respond to the request or deny or authorize the request, as appropriate, within forty-eight hours after the insurer or plan receives the form.

(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 services 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 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.

The department or its designee shall approve or deny a prior authorization request made on the form established under this section not later than forty-eight hours after the department or its designee receives the form.

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