

Proponent Testimony – HB 220: Prior Authorization
Ohio House Insurance Committee
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Ohio State Medical Association

October 28, 2025

Chair Lampton, Vice Chair Craig, Ranking Member Hall, and members of the House Insurance Committee, my name is Monica Hueckel and I am testifying today on behalf of the Ohio State Medical Association (OSMA), the state's oldest and largest professional organization representing Ohio physicians, medical residents, and medical students. We would like to thank the committee for the opportunity to testify in support of House Bill 220, regarding prior authorization.

Prior authorization is the process by which health plans require health care providers to obtain approval in advance from the insurer before a medical service or treatment can be delivered to the patient and qualify for payment. The process is incredibly cumbersome, and OSMA hears from our physician members about prior authorization more than any other issue of concern. It is clear that Ohio has more work to do to make this system work better for physicians and their patients, and that is the main goal of House Bill 220. This bill addresses four main components of prior authorization in an effort to streamline the process and eliminate persistent barriers to care:

Retroactive denials

First, HB 220 would prohibit retroactive denials of prior authorization, except in the instance of a non-covered benefit or lack of coverage at the time of service. Retroactive denials of prior authorizations significantly and negatively impact both physician practices and patient care outcomes. When insurers authorize treatments or procedures, but subsequently deny claims for those treatments or procedures after the fact, this creates extreme financial uncertainty for providers. Insurers revoking their decision to approve and pay a claim after the service is completed may also leave patients unexpectedly responsible for the full cost after being told it would be covered, and retroactive denial can also be a massive disruption in continuity of care.

Peer-to-peer reviews

The peer-to-peer process occurs when an ordering physician discusses the need for a procedure or drug with another physician who works for the payer in order to obtain a prior authorization approval or to appeal a previously denied prior authorization request. Unfortunately, physicians often report receiving a prior authorization denial for a prescribed medication or procedure and being required to plead their case in order to move forward by speaking with someone who does not have the clinical expertise needed to make the decision in question. The insurer-paid health professional on the other end of this exchange is not always a physician, or even if they are, they are from a completely different specialty or have little to no knowledge about the treatment or health condition being discussed.

HB 220 contains provisions which would require peer-to-peer reviews to be between the practitioner requesting the service in question and a clinical peer, and that peer must identify themselves, including

specialty and relevant qualifications. This ensures that the individuals making these determinations are actually clinically informed enough to be able to adequately review cases for medical necessity.

Drug prior authorizations for chronic conditions

Current Ohio law requires that drug prior authorizations for maintenance medications to treat a chronic condition be considered valid for a year. HB 220 would build upon this by requiring that initial year-long prior authorization approval to account for dosage adjustments. Some chronic diseases do not have a one-size-fits-all course of treatment and may require adjustment of medication doses to effectively treat the illness. HB 220 would allow for physicians to adjust the dose of a medication without the need to go through the prior authorization and appeals process again. Dose adjustment is not always simply moving up in dosage, as sometimes a physician may adjust a dose down for a medication. Adjusting a dose is not providing a whole different treatment, but some insurance plans treat the adjustment as such, which can lead to lengthy and burdensome processes to appeal to get the medication approved again.

Many patients do not understand the appeals process and may end up deteriorating during the length of the appeal, or be forced to move to a different drug which could have reduced safety or efficacy for the patient. Considering that nearly half of all Americans live with a chronic medical condition, and many of these patients rely on prescription medicines to live their most productive lives, this component of HB 220 is a reasonable and common-sense enhancement of current prior authorization law in Ohio.

Charging for appeals of denials

While we have yet to see this happen in Ohio, it has been reported that in other states, some insurers may be attempting to charge fees when providers appeal prior authorization denials. HB 220 contains language prohibiting this practice simply as a proactive protection for Ohio providers, shielding them from unfair additional costs during the appeals process.

To conclude, I emphasize once again that this issue is the most common one we hear about from our physician members of all specialties and practice settings, from all over the state. We believe that in order for Ohio to work to make our health care system better, it is necessary to listen to the providers out on the front lines of patient care about the issues that hinder their ability to provide that care in a timely and efficient way.

OSMA is thankful to members of the committee for your attention to our comments and concerns on this legislation, and appreciates the opportunity to be a meaningful contributor to the legislative process. I would be happy to answer any questions.