Proposed Ohio Legislation: Insurance Accountability and Access to Addiction & Pain Care

Purpose:

To reduce opioid-related deaths and healthcare costs in Ohio by ensuring timely, transparent, and evidence-based insurance practices regarding addiction medicine and pain management services, particularly for high-risk patients.

1. Mandatory Written Insurance Responses

- All health insurers (including Medicaid Managed Care Entities and Medicare providers operating in Ohio) must provide a written response to any inquiry from a provider or patient regarding:
    - Denials of services (including SBIRT, addiction medicine, and pain management)
    - Recoupment or withholding of funds
    - Credentialing or network participation status
    - Allegations of blocking access to care
- The written response must be delivered within 30 calendar days of the inquiry.
- Failure to respond within 30 days will trigger:
    - An automatic audit by the Ohio Department of Insurance or Department of Medicaid
    - Potential citation and fines
    - For repeated or egregious violations, suspension or revocation of the insurer's license to provide Medicare and Medicaid services in Ohio[1][2][3].

2. Independent Expert Review of Denials

- Any denial of addiction medicine or pain management services (including but not limited to SBIRT, urine drug screens, nerve conduction studies, and non-opioid pain interventions) must be reviewed by two independent, board-certified experts in addiction medicine or pain medicine not employed by the insurer or its affiliates[4][2].
- The review must consider:

    - Ohio's legal requirements for pain management clinics (e.g., OAC § 4731-11-14, OAC § 4731-29-01)
    - Evidence-based guidelines and the patient's risk profile (e.g., NARX score, comorbidities)[4][2].
- The insurer must provide the provider and patient with the experts' written opinions as part of the denial explanation.

3. Robust Appeals Mechanism

- All denials must include clear instructions for initiating an appeal.
- The appeals process must allow:
    - Direct communication between the treating provider and the insurer's medical director
    - Submission of supporting documentation and evidence-based guidelines
    - A second, independent specialty review if the first appeal is denied[5].
- Appeals must be resolved within 30 days of submission; unresolved appeals automatically escalate to the Ohio Department of Insurance or Department of Medicaid for expedited review.

4. Timely Payment and Recoupment Protections

- Insurers must comply with Ohio's Prompt Pay Law for all covered services, including addiction and pain management, with strict timeframes for claim processing and payment[6].
- Any recoupment or withholding of funds must be justified in writing, with detailed explanation and an opportunity for provider appeal before funds are seized[1].
- Unjustified or retaliatory recoupments, or those motivated by financial objectives rather than medical necessity, will result in:
    - Fines of up to $50,000 per violation
    - Restitution of improperly withheld funds
    - Potential loss of license to operate state-funded insurance programs

5. Credentialing and Network Access

- Insurers must process credentialing applications within 30 days, using Ohio's centralized credentialing system (PNM/CAQH)[7][3].
- Unjustified delays or denials in credentialing, particularly those affecting access to high-risk populations, will trigger state review and potential sanctions[8][1].

6. Enforcement and Reporting

- The Ohio Department of Insurance and Department of Medicaid must publicly report quarterly on:
  - The number and nature of complaints regarding denials, recoupments, and credentialing
  - Outcomes of audits, citations, and enforcement actions
  - Trends in opioid-related morbidity and mortality

7. Justification and Expected Impact

- SBIRT and evidence-based pain management are required by Ohio law and national guidelines for high-risk patients[4][2].
- Denial or delay of these services increases opioid mortality, crime, and healthcare costs; evidence shows that appropriate screening/intervention saves lives and reduces expenditures by preventing overdoses, hospitalizations, and criminal justice involvement[4][2].
- This legislation will align insurer practices with Ohio's public health priorities, restore provider trust, and protect vulnerable populations.

Summary:

This legislation will ensure that insurers are accountable, transparent, and guided by medical necessity—not financial objectives—when making decisions that affect access to life-saving addiction and pain management care. By enforcing timely responses, independent reviews, and robust appeals, Ohio can save hundreds of lives annually and reduce the economic burden of the opioid crisis[4][2].

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1. Ohio-Medicaid-ignores-patient-complaints.pdf
2. OVV-DOJ-petition.pdf
3. https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-42
4. Inurance-Article-A.pdf
5. https://drugfree.org/article/i-just-got-denied-coverage-now-what-how-to-file-an-insurance-appeal-for-substance-use-disorder/
6. https://insurance.ohio.gov/companies/market-conduct/resources/ohios-prompt-pay-law
7. https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/ohio-rise/providers/pdf/abhohiorise_provider_manual.pdf
8. Molina-blocking-access-vMt-Carmel-System.pdf