As Introduced

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Representatives Schneider, Beatty

Cosponsors: Representatives Combs, Dodd, Peterson, Flowers, Seitz, Webster, Schindel, Yuko, Bubp, Sykes, McGregor, J., Lundy, Blessing, Chandler, Carano, Oelslager, Skindell, Patton, Hughes, Stebelton, Wagoner

A B I L L

To amend sections 1739.05 and 1751.01 and to enact section 3923.71 of the Revised Code to require certain health care policies, contracts, agreements, and plans to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes and for diabetes self-management education.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1739.05 and 1751.01 be amended and section 3923.71 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, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.71, 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. 1751.01. As used in this chapter:

(A)(1) "Basic health care services" means the following services when medically necessary:

(a) Physician's services, except when such services are supplemental under division (B) of this section;

(b) Inpatient hospital services;

(c) Outpatient medical services;

(d) Emergency health services;

(e) Urgent care services;

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;

(i) Diabetes self-management education, medical nutrition therapy, and equipment, supplies, and medication, as provided in section 3923.71 of the Revised Code.

"Basic health care services" does not include experimental procedures.

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of

beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the department of job and family services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic

health care services to increase by more than one per cent per year.

(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a

health care plan.

(L) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

(M) "Health care services" means basic, supplemental, and specialty health care services.

(N) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

(O) "Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and

drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

(Q) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

(R) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

(S)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as

an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

(T) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

(U) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

(V) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

(W) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

(X) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

(Y) "Provider sponsored organization" means a corporation, as defined in division (H) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

(Z) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

(AA) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation

in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

(BB) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 3923.71. (A) As used in this section:

(1) "Health benefit plan" means any of the following when the contract, policy, or plan provides payment or reimbursement for the costs of health care services other than for specific diseases or accidents only:

(a) An individual, group, or blanket policy of sickness and accident insurance that provides coverage other than for specific diseases or accidents only, for hospital indemnity only, for supplemental medicare benefits only, or for any other supplemental benefits only, and that is delivered, issued for delivery, or renewed in this state;

(b) An individual or group contract of a health insuring corporation;

(c) A public employee benefit plan;

(d) A multiple employer welfare arrangement as defined in section 1739.01 of the Revised Code.

(2) "Equipment, supplies and medication" includes both of the following, when determined to be medically necessary:

(a) Nonexperimental equipment, single-use medical supplies,

and related devices approved by the United States food and drug administration for the treatment and management of diabetes;

(b) Nonexperimental medication, insulin, glucagons, and insulin syringes for controlling blood sugar approved by the United States food and drug administration for the treatment and management of diabetes.

(3) "Medical nutrition therapy" means nutritional diagnostic, therapeutic, and counseling services for the purpose of diabetes disease management provided by a dietitian licensed under Chapter 4759. of the Revised Code or a nutrition professional pursuant to a physician's referral.

(4) "Diabetes self-management education" means an interactive and ongoing process prescribed by a physician involving a patient with diabetes and the physician or other professional with expertise in diabetes. "Diabetes self-management education" includes assessment and identification of the patient's diabetes needs and management goals, education and behavioral intervention directed toward helping the patient attain self-management goals, and evaluation of the patient's progress in attaining self-management goals.

(B) Notwithstanding section 3901.71 of the Revised Code, each health benefit plan shall provide benefits for the expenses of the following, when determined to be medically necessary:

(1) Equipment, supplies, and medication;

(2) Medical nutrition therapy;

(3) Diabetes self-management education.

(C) All of the following apply to the provision of benefits for the expenses of diabetes self-management education and medical nutrition therapy:

(1) The benefits shall cover the expenses of diabetes

self-management education and medical nutrition therapy only if the education is determined to be medically necessary and is prescribed by a physician or other individual whose professional practice established by licensure under the Revised Code includes the authority to prescribe the education.

(2) During the first twelve-month period immediately after a patient begins to receive diabetes self-management education, the benefits shall cover the expenses of ten hours of education, which may include medical nutrition therapy in a program based on the standards for diabetes self-management education as outlined in the American diabetes association's standards of care.

(3) In each year following the provision of coverage under division (C)(2) of this section, the benefits shall cover the expenses of two hours of diabetes self-management education, of which one hour may be used for medical nutrition therapy, as an annual maintenance program for the patient, if the education is medically necessary and prescribed by a physician or other individual whose professional practice established by licensure under the Revised Code includes the authority to prescribe the education. Any coverage provided for the expenses of a required medical examination shall not reduce the coverage provided for the expenses of the patient's annual education maintenance program described in this section.

(4) The benefits shall cover the expenses of any diabetes self-management education determined to be medically necessary, whether provided during home visits, in a group setting, or by individual counseling.

(5) The benefits shall cover the expenses of diabetes self-management education only if the education is provided by an individual with expertise in diabetes care, whose professional practice established by licensure under the Revised Code includes the authority to provide the education. The benefits shall cover

the expenses of medical nutrition therapy only if the therapy is provided by a dietitian licensed under Chapter 4759. of the Revised Code unless the patient's health plan does not include a dietitian in its network of providers.

(D) A health benefit plan is not required to provide benefits for diabetes care pursuant to division (B) of this section if all of the following apply:

(1) The health benefit plan insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diabetes care pursuant to division (B) of this section for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (D)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (D)(1) and (2) of this section:

(a) Incurred claims for diabetes care pursuant to division (B) of this section for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

Section 2. That existing sections 1739.05 and 1751.01 of the Revised Code are hereby repealed.

Section 3. Section 3923.71 of the Revised Code shall apply only to health benefit plans as defined in that section that are established or modified, delivered, issued for delivery, or renewed in this state on or after the effective date of this act.