As Reported by the Senate Health, Human Services and Aging Committee

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Representative Daniels

Cosponsors: Representatives Ujvagi, Flowers, Goodwin, Collier, Zehringer, Strahorn, Otterman, J., Hagan, R., Budish, Chandler, Combs, Domenick, Evans, Gerberry, Harwood, Letson, Szollosi
Senators Wagoner, Seitz

A B I L L

To amend sections 3923.05 and 3923.80 and to enact sections 3701.86, 3701.861, 3923.82, and 4731.72 of the Revised Code and to amend Section 5 of Sub. H.B. 125 of the 127th General Assembly regarding billing for anatomic pathology services, health benefits for routine patient care during cancer clinical trials, health benefits for injuries resulting from use of alcohol or drugs, and most favored nation clauses in health care contracts.

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

Section 1. That sections 3923.05 and 3923.80 be amended and sections 3701.86, 3701.861, 3923.82, and 4731.72 of the Revised Code be enacted to read as follows:

Sec. 3701.86. As used in this section and in section 3701.861 of the Revised Code:

(A) "Anatomic pathology services" means all of the following:

(1) Histopathology or surgical pathology;

(2) Cytopathology;

(3) Hematology;

(4) Subcellular or molecular pathology;

(5) Blood banking services performed by pathologists.

(B) "Assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under an insurance policy, subscription contract, or health care plan by an insured, subscriber, or plan enrollee to a health care provider, hospital, or other health care facility.

(C) "Clinical laboratory" means a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of substances derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or in the assessment or impairment of the health of human beings.

(D) "Cytopathology" means the microscopic examination of cells from fluids, aspirates, washings, brushings, or smears, including a Papanicolaou smear (PAP smear or test).

(E) "Hematology" means the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist.

(F) "Histologic processing" means fixation, processing, embedding, microtomy, and other special staining, including histochemical or immunohistochemical staining and in situ hybridization of clinical human tissues or cells, for pathological

examination.

(G) "Histopathology" or "surgical pathology" means the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician.

(H) "Insurer" means a person authorized under Title XXXIX of the Revised Code to engage in the business of insurance in this state, a health insuring corporation, or an entity that is self-insured and provides benefits to its employees or members.

(I) "Physician" means an individual authorized by Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(J) "Referring clinical laboratory" means a clinical laboratory that refers a patient specimen to another clinical laboratory for an anatomic pathology service, but excludes a laboratory in the office of one or more physicians that refers a specimen and does not perform the professional component of the anatomic pathology service, as that component is defined in section 4731.72 of the Revised Code.

(K) "Subcellular or molecular pathology" means the assessment of a patient specimen for the detection, localization, measurement, or analysis of one or more protein or nucleic acid targets performed or interpreted by or under supervision of a pathologist.

Sec. 3701.861. (A) No clinical laboratory shall present or cause to be presented a claim, bill, or demand for payment for anatomic pathology services to any person or entity other than the following:

(1) The patient who receives the services or another

individual, such as a parent, spouse, or guardian, who is responsible for the patient's bills;

(2) A responsible insurer or other third-party payor of a patient who receives the services;

(3) A hospital, public health clinic, or not-for-profit health clinic ordering the services;

(4) A referring clinical laboratory;

(5) A governmental agency or any person acting on behalf of a governmental agency;

(6) A physician who is permitted to bill for the services under division (D) of section 4731.72 of the Revised Code.

(B) Nothing in this section shall be construed to do either of the following:

(1) Mandate the assignment of benefits for anatomic pathology services;

(2) Prohibit a clinical laboratory that provides anatomic pathology services from billing a referring clinical laboratory for anatomic pathology services in instances in which the referring clinical laboratory sends one or more samples to the clinical laboratory for purposes of having a specialist perform analysis, consultation, or histologic processing.

Sec. 3923.05. Except as provided in section 3923.07 of the Revised Code, no policy of sickness and accident insurance delivered, issued for delivery, or used in this state shall contain provisions respecting the matters set forth in this section unless such provisions are in the words in which the same appear in this section. Any such provisions in any such policy shall be preceded by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent

of insurance may approve.

(A) A provision as follows: Change of occupation. If the insured be injured or contract sickness after having changed ~~his~~ the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes ~~his~~ the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification for occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(B) A provision as follows: Misstatement of age. If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(C) A provision as follows:

(1) Other insurance in this insurer. If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... in excess of ..... dollars, the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to ~~his~~ the insured's estate.

The insurer shall insert the type of coverage or coverages in the first blank space in the provision in division (C)(1) of this section and the maximum limit of indemnity or indemnities in the second blank space in the provision in division (C)(1) of this section.

(2) In lieu of the foregoing provision in division (C)(1) of this section, a provision as follows: Other insurance in this insurer. Insurance effective at any time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, ~~his~~ the insured's beneficiary or ~~his~~ the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(D) A provision as follows: Insurance with other insurers. If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of

applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the provision in division (D) of this section is included in a policy of sickness and accident insurance which also contains the provision in division (E) of this section, the insurer shall add to the caption of the provision in division (D) of this section the following: Expense incurred benefits.

The insurer may at its option include in the provision in division (D) of this section a definition of "other valid coverage" approved as to form by the superintendent. Such definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of the Dominion of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition in the provision in division (D) of this section, "other valid coverage" as used in such provision shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations.

For the purpose of applying the provision in division (D) of this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice.

In applying the provision in division (D) of this section no

third party liability coverage shall be included as "other valid coverage."

(E) A provision as follows: Insurance with other insurers. If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which the insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

If the provision in division (E) of this section is included in a policy of sickness and accident insurance which also contains the provision in division (D) of this section, the insurer shall add to the caption of the provision in division (E) of this section the following: Other benefits.

The insurer may at its option include in the provision in division (E) of this section a definition of "other valid coverage" approved as to form by the superintendent. Such definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of the Dominion of Canada, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition in the provision in division (E) of this section, "other valid coverage" as used in such provision shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations.

For the purpose of applying the provision in division (E) of this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice.

In applying the provision in division (E) of this section no third party liability coverage shall be included as "other valid coverage."

(F) A provision as follows: Relation of earnings to insurance. If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or ~~his~~ the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall ~~exced~~ exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall this operate to reduce benefits other than those payable for loss of time.

The provision in division (F) of this section may be placed

only in a policy of sickness and accident insurance which the insured has a right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or in a policy of sickness and accident insurance issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue.

The insurer may at its option include in the provision in division (F) of this section a definition of "valid loss of time coverage" approved as to form by the superintendent. Such definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of the Dominion of Canada or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition in the provision in division (F) of this section "valid loss of time coverage" as used in such provision shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(G) A provision as follows: Unpaid premium. Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(H) A provision as follows: Conformity with state statutes. Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(I) A provision as follows: Illegal occupation. The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

~~(J) A provision as follows: Intoxicants and narcotics. The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.~~

Sec. 3923.80. (A) ~~No~~ Notwithstanding section 3901.71 of the Revised Code, no health benefit plan or public employee benefit plan shall deny coverage for the costs of any routine patient care administered to an insured participating in any stage of an eligible cancer clinical trial, if that care would be covered under the plan if the insured was not participating in a clinical trial.

(B) The coverage that may not be excluded under division (A) of this section is subject to all terms, conditions, restrictions, exclusions, and limitations that apply to any other coverage under the plan, policy, or arrangement for services performed by participating and nonparticipating providers. Nothing in this section shall be construed as requiring reimbursement to a provider or facility providing the routine care that does not have a health care contract with the entity issuing the health benefit plan or public employee benefit plan, or as prohibiting the entity issuing a health benefit plan or public employee benefit plan that does not have a health care contract with the provider or facility providing the routine care from negotiating a single case or other agreement for coverage.

(C) As used in this section:

(1) "Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

(a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.

(b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

(c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.

(d) The trial does one of the following:

(i) Tests how to administer a health care service, item, or drug for the treatment of cancer;

(ii) Tests responses to a health care service, item, or drug for the treatment of cancer;

(iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;

(iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.

(e) The trial is approved by one of the following entities:

(i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;

(ii) The United States food and drug administration;

(iii) The United States department of defense;

(iv) The United States department of veterans' affairs.

(2) "Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the

clinical trial and that is not routine patient care.

(3) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.

(4) "Routine patient care" means all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

(5) For purposes of this section, a health benefit plan or public employee benefit plan may exclude coverage for any of the following:

(a) A health care service, item, or drug that is the subject of the cancer clinical trial;

(b) A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;

(c) An investigational or experimental drug or device that has not been approved for market by the United States food and drug administration;

(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;

(e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;

(f) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the

sponsor of the cancer clinical trial.

Sec. 3923.82. (A) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, no health benefit plan or public employee benefit plan shall contain a provision that limits or excludes an insured's coverage under the plan for a loss or expense the insured sustains that is the result of the insured's use of alcohol or other drugs or both and the loss or expense is otherwise covered under the plan.

(C) Nothing in this section shall be construed as doing either of the following:

(1) Requiring coverage for the treatment of alcohol or substance abuse except as otherwise required by law;

(2) Prohibiting the enforcement of an exclusion based on injuries sustained by an insured during the commission of an offense by the insured in which the insured is convicted of or pleads guilty or no contest to a felony.

(D) Not later than four years after the effective date of this section, the department of insurance shall conduct an analysis of the impact of the requirements of this section on the cost of and coverage provided by health benefit plans in this state and prepare a written report of its findings from the analysis. The department shall submit the report to the governor and, in accordance with section 101.68 of the Revised Code, to the general assembly.

Sec. 4731.72. (A) As used in this section:

(1) "Anatomic pathology services," "assignment of benefits," "histologic processing," "insurer," "physician," and "referring

clinical laboratory" have the same meanings as in section 3701.86 of the Revised Code.

(2) "Professional component of an anatomic pathology service" means the entire anatomic pathology service other than histologic processing.

(3) "Technical component of an anatomic pathology service" means only histologic processing.

(B) No physician shall present or cause to be presented a claim, bill, or demand for payment for anatomic pathology services to any person or entity other than the following:

(1) The patient who receives the services or another individual, such as a parent, spouse, or guardian, who is responsible for the patient's bills;

(2) A responsible insurer or other third-party payor of a patient who receives the services;

(3) A hospital, public health clinic, or not-for-profit health clinic ordering the services;

(4) A referring clinical laboratory;

(5) A governmental agency or any person acting on behalf of a governmental agency;

(6) A physician who is permitted to bill for the services under division (D) of this section.

(C) Except as provided in division (D) of this section, no physician shall charge, bill, or otherwise solicit payment, directly or indirectly, for anatomic pathology services unless the services are personally rendered by the physician or rendered under the on-site supervision of the physician.

(D)(1) A physician who performs the professional component of an anatomic pathology service on a patient specimen may bill for the amount incurred in doing either of the following:

(a) Having a clinical laboratory or another physician perform the technical component of the anatomic pathology service;

(b) Obtaining another physician's consultation regarding the patient specimen.

(2) A physician may bill for having a clinical laboratory or another physician perform an anatomic pathology service on a dermatology specimen, but only if the billing physician discloses to the person or entity being billed both of the following:

(a) The name and address of the clinical laboratory or physician who performed the service;

(b) The amount the billing physician was charged by or paid to the clinical laboratory or physician who performed the service.

(E) A violation of division (B) or (C) of this section constitutes a reason for taking action under division (B)(20) of section 4731.22 of the Revised Code.

(F) Nothing in this section shall be construed to mandate the assignment of benefits for anatomic pathology services.

Section 2. That existing sections 3923.05 and 3923.80 of the Revised Code are hereby repealed.

Section 3. That existing Section 5 of Sub. H.B. 125 of the 127th General Assembly be amended to read as follows:

Sec. 5. (A) As used in this section and Section 6 of ~~this act~~ Sub. H.B. 125 of the 127th General Assembly:

(1) "Most favored nation clause" means a provision in a health care contract that does any of the following:

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower

price than the payment specified in the contract;

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

(2) "Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code, as enacted by ~~this act~~ Sub. H.B. 125 of the 127th General Assembly.

(B) ~~No~~ With respect to a contracting entity and a provider other than a hospital, no health care contract that includes a most favored nation clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended or renewed to include a most favored nation clause, for a period of ~~two~~ three years after the effective date of ~~this act, subject to extension as provided in Section 6 of this act~~ Sub. H.B. 125 of the 127th General Assembly. ~~This~~

(C) With respect to a contracting entity and a hospital, no health care contract that includes a most favored nation clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended or renewed to include a most favored nation clause, for a period of two years after the effective date of Sub. H.B. 125 of the 127th General Assembly,

subject to extension as provided in Section 6 of Sub. H.B. 125 of the 127th General Assembly.

(D) This section does not apply to and does not prohibit the continued use of a most favored nation clause in a health care contract that is between a contracting entity and a hospital and that is in existence on the effective date of ~~this act~~ Sub. H.B. 125 of the 127th General Assembly even if the health care contract is materially amended with respect to any provision of the health care contract other than the most favored nation clause during the two-year period specified in this section or during any extended period of time as provided in Section 6 of ~~this act~~ Sub. H.B. 125 of the 127th General Assembly.

Section 4. That existing Section 5 of Sub. H.B. 125 of the 127th General Assembly is hereby repealed.

Section 5. Sections 3923.05 and 3923.82 of the Revised Code, as amended or enacted by this act, shall apply only to health benefit plans that are delivered, issued for delivery, or renewed in this state on or after one hundred eighty days after the effective date of this act.