As Introduced

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S. B. No. 99

Senator Gardner

Cosponsors: Senators Coughlin, Boccieri, Morano, Spada, Schuring, Roberts, Mumper, Mason, Miller, D., Clancy, Padgett, Cafaro, Goodman

A BILL

To amend section 1751.01 and to enact sections 1751.69, 3923.71, and 3923.72 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. 1 2 3 4 5 6 7 8

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

Section 1. That section 1751.01 be amended and sections 1751.69, 3923.71, and 3923.72 of the Revised Code be enacted to read as follows: 9 10 11

Sec. 1751.01. As used in this chapter: 12

(A)(1) "Basic health care services" means the following services when medically necessary: 13 14

(a) Physician's services, except when such services are supplemental under division (B) of this section; 15 16

(b) Inpatient hospital services; 17

(c) Outpatient medical services; 18

(d) Emergency health services; 19

(e) Urgent care services; 20

(f) Diagnostic laboratory services and diagnostic and 21
therapeutic radiologic services; 22

(g) Diagnostic and treatment services, other than 23
prescription drug services, for biologically based mental 24
illnesses; 25

(h) Preventive health care services, including, but not 26
limited to, voluntary family planning services, infertility 27
services, periodic physical examinations, prenatal obstetrical 28
care, and well-child care~~.~~; 29

(i) Diabetes self-management education, medical nutrition 30
therapy, and equipment, supplies, and medication, as provided in 31
section 1751.69 of the Revised Code. 32

"Basic health care services" does not include experimental 33
procedures. 34

Except as provided by divisions (A)(2) and (3) of this 35
section in connection with the offering of coverage for diagnostic 36
and treatment services for biologically based mental illnesses, a 37
health insuring corporation shall not offer coverage for a health 38
care service, defined as a basic health care service by this 39
division, unless it offers coverage for all listed basic health 40
care services. However, this requirement does not apply to the 41
coverage of beneficiaries enrolled in Title XVIII of the "Social 42
Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, 43
pursuant to a medicare contract, or to the coverage of 44
beneficiaries enrolled in the federal employee health benefits 45
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 46
beneficiaries enrolled in Title XIX of the "Social Security Act," 47

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. 48 49 50 51 52 53 54 55

(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. 56 57 58 59 60 61 62 63 64 65 66

(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: 67 68 69 70 71

(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 72 73 74 75 76 77 78 79

year. 80

(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. 81 82 83 84 85 86 87

(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: 88 89 90

(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. 91 92 93 94 95 96

(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. 97 98 99 100

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 101 102

(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: 103 104 105 106 107

(a) Services of facilities for intermediate or long-term care, or both; 108 109

(b) Dental care services; 110

(c) Vision care and optometric services including lenses and frames; 111 112

(d) Podiatric care or foot care services; 113

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses; 114 115

(f) Short-term outpatient evaluative and crisis-intervention mental health services; 116 117

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction; 118 119

(h) Home health services; 120

(i) Prescription drug services; 121

(j) Nursing services; 122

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code; 123 124

(l) Physical therapy services; 125

(m) Chiropractic services; 126

(n) Any other category of services approved by the superintendent of insurance. 127 128

(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. 129 130 131 132 133

(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. 134 135 136 137 138

(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. 139 140 141 142 143 144 145

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers. 146 147

(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. 148 149 150

(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation. 151 152 153

(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state. 154 155 156

(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. 157 158 159 160 161 162 163

(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation. 164 165 166

(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 167 168 169

health care plan. 170

(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. 171 172 173 174 175

(M) "Health care services" means basic, supplemental, and specialty health care services. 176 177

(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. 178 179 180 181

(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. 182 183 184 185 186 187 188 189 190

"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 191 192 193 194 195 196 197 198 199 200

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. 201 202 203 204 205 206 207 208 209 210 211

(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. 212 213 214 215 216 217 218

(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. 219 220 221 222

(R) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment. 223 224 225

(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. 226 227 228 229

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as 230 231

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. 232 233 234 235 236 237 238 239

(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. 240 241 242 243

(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. 244 245 246 247 248

(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. 249 250 251 252 253 254 255

(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. 256 257 258 259 260 261 262

(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. 263 264 265 266 267 268 269 270 271 272 273 274 275 276

(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. 277 278 279 280 281 282 283 284 285 286 287 288

(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. 289 290 291 292

(AA) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation 293 294

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. 295 296 297

(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. 298 299 300 301 302 303 304 305

Sec. 1751.69. (A) As used in this section: 306

(1) "Equipment, supplies, and medication" includes both of the following, when determined to be medically necessary: 307 308

(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; 309 310 311

(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. 312 313 314 315

(2) "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. 316 317 318 319 320

(3) "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" 321 322 323 324

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. 325 326 327 328 329

(B) Notwithstanding section 3901.71 of the Revised Code, each individual or group health insuring corporation policy, contract, or agreement that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of the following, when determined to be medically necessary: 330 331 332 333 334

(1) Equipment, supplies, and medication; 335

(2) Medical nutrition therapy; 336

(3) Diabetes self-management education. 337

(C) All of the following apply to the provision of benefits for the expenses of diabetes self-management education and medical nutrition therapy: 338 339 340

(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. 341 342 343 344 345 346

(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. 347 348 349 350 351 352

(3) In each year following the provision of coverage under division (C)(2) of this section, the benefits shall cover the 353 354

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. 355 356 357 358 359 360 361 362 363 364

(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. 365 366 367 368

(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. 369 370 371 372 373 374 375 376 377

(D) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diabetes self-management education and medical nutrition therapy in combination with the offer of coverage for all other listed basic health care services if all of the following apply: 378 379 380 381 382

(1) 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 diabetes self-management education and medical 383 384 385 386

nutrition therapy 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. 387 388 389 390 391

(2) 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 (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 health insuring corporation for the coverage of basic health care services. 392 393 394 395 396 397 398

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (D)(1) and (D)(2) of this section: 399 400 401

(a) Incurred claims for diabetes self-management education and medical nutrition therapy 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. 402 403 404 405 406 407

(b) 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. 408 409 410 411

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 412 413

Sec. 3923.71. (A) As used in this section: 414

(1) "Equipment, supplies and medication" includes both of the following, when determined to be medically necessary: 415 416

(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; 417 418 419

(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. 420 421 422 423

(2) "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. 424 425 426 427 428

(3) "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. 429 430 431 432 433 434 435 436 437

(B) Notwithstanding section 3901.71 of the Revised Code, each policy of individual, group, or blanket 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, shall provide benefits for the expenses of the following, when determined to be medically necessary: 438 439 440 441 442 443 444 445

(1) Equipment, supplies, and medication; 446

(2) Medical nutrition therapy; 447

(3) Diabetes self-management education. 448

(C) All of the following apply to the provision of benefits for the expenses of diabetes self-management education and medical nutrition therapy: 449 450 451

(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. 452 453 454 455 456 457

(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. 458 459 460 461 462 463

(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. 464 465 466 467 468 469 470 471 472 473 474 475

(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 476 477 478

individual counseling. 479

(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. 480 481 482 483 484 485 486 487 488

(D) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diabetes self-management education and medical nutrition therapy in combination with the offer of coverage for all other listed basic health care services if all of the following apply: 489 490 491 492 493

(1) 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 diabetes self-management education and medical nutrition therapy 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. 494 495 496 497 498 499 500 501 502

(2) 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 (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 health insuring corporation for the coverage of basic health care services. 503 504 505 506 507 508 509

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (D)(1) and (D)(2) of this section: 510 511 512

(a) Incurred claims for diabetes self-management education and medical nutrition therapy 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. 513 514 515 516 517 518

(b) 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. 519 520 521 522

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 523 524

Sec. 3923.72. (A) As used in this section: 525

(1) "Equipment, supplies, and medication" includes both of the following, when determined to be medically necessary: 526 527

(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; 528 529 530

(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. 531 532 533 534

(2) "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. 535 536 537 538 539

(3) "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. 540 541 542 543 544 545 546 547 548

(B) Notwithstanding section 3901.71 of the Revised Code, each public employee benefit plan that is established or modified in this state shall provide benefits for the expenses of the following, when determined to be medically necessary: 549 550 551 552

(1) Equipment, supplies, and medication; 553

(2) Medical nutrition therapy; 554

(3) Diabetes self-management education. 555

(C) All of the following apply to the provision of benefits for the expenses of diabetes self-management education and medical nutrition therapy: 556 557 558

(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. 559 560 561 562 563 564

(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. 565 566 567 568 569 570

(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. 571 572 573 574 575 576 577 578 579 580 581 582

(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. 583 584 585 586

(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. 587 588 589 590 591 592 593 594 595

(D) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diabetes self-management education and medical nutrition therapy in combination with the offer of coverage for all other listed basic health care services if all of the following apply: 596 597 598 599 600

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of 601 602

actuaries to the superintendent of insurance showing that incurred claims for diabetes self-management education and medical nutrition therapy 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. 603 604 605 606 607 608 609

(2) 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 (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 health insuring corporation for the coverage of basic health care services. 610 611 612 613 614 615 616

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (D)(1) and (D)(2) of this section: 617 618 619

(a) Incurred claims for diabetes self-management education and medical nutrition therapy 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. 620 621 622 623 624 625

(b) 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. 626 627 628 629

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 630 631

Section 2. That existing section 1751.01 of the Revised Code 632

is hereby repealed. 633

Section 3. Section 1751.69 of the Revised Code shall apply 634
only to policies, contracts, and agreements that are delivered, 635
issued for delivery, or renewed in this state on or after the 636
effective date of this act; section 3923.71 of the Revised Code 637
shall apply to policies of sickness and accident insurance on or 638
after the effective date of this act in accordance with section 639
3923.01 of the Revised Code; and section 3923.72 of the Revised 640
Code shall apply only to plans that are established or modified in 641
this state on or after the effective date of this act. 642