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Representatives Boyd, Gardner

Cosponsors: Representatives Weddington, Mallory, Domenick, Newcomb, Luckie, Miller, Yuko, Williams, B., Murray, Foley, Hagan, Chandler, Harris, Skindell, Oelslager, Okey, Pryor, Phillips, Williams, S., Bolon, Letson, Stewart, Brown, Garrison, Fende, Book, Winburn, Garland, Patten, Belcher, Carney, Celeste, DeBose, Dodd, Dyer, Harwood, Heard, Lundy, Moran, Szollosi, Ujvagi, Yates

A BILL

To amend sections 1739.05 and 1751.01 and to enact sections 1751.69 and 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 and to create the Small Business Health Care Affordability Task Force. 1 2 3 4 5 6 7 8 9

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

Section 1. That sections 1739.05 and 1751.01 be amended and sections 1751.69 and 3923.71 of the Revised Code be enacted to read as follows: 10 11 12

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the 13 14

Revised Code and that operates a group self-insurance program may be established only if any of the following applies: 15 16

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers. 17 18

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals. 19 20

(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. 21 22 23

(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, 3923.80, 3924.031, 3924.032, and 3924.27 of the Revised Code. 24 25 26 27 28 29 30 31

(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. 32 33 34 35 36

(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. 37 38 39 40 41 42 43 44

Sec. 1751.01. As used in this chapter: 45

(A)(1) "Basic health care services" means the following services when medically necessary: 46 47

(a) Physician's services, except when such services are supplemental under division (B) of this section; 48 49

(b) Inpatient hospital services; 50

(c) Outpatient medical services; 51

(d) Emergency health services; 52

(e) Urgent care services; 53

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services; 54 55

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses; 56 57 58

(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; 59 60 61 62

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code; 63 64 65

(j) Diabetes self-management education, medical nutrition therapy, and equipment, supplies, and medication, as provided in section 1751.69 of the Revised Code. 66 67 68

"Basic health care services" does not include experimental procedures. 69 70

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic 71 72

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 medicare 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 medicaid recipients, or to the coverage of participants of the children's buy-in program, 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. 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87

(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. 88 89 90 91 92 93 94 95 96 97 98

(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: 99 100 101 102 103

(a) The health insuring corporation submits documentation 104

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. 105 106 107 108 109 110 111 112

(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. 113 114 115 116 117 118 119

(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: 120 121 122

(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. 123 124 125 126 127 128

(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. 129 130 131 132

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 133 134

(B)(1) "Supplemental health care services" means any health 135

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: 136 137 138 139

(a) Services of facilities for intermediate or long-term care, or both; 140 141

(b) Dental care services; 142

(c) Vision care and optometric services including lenses and frames; 143 144

(d) Podiatric care or foot care services; 145

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses; 146 147

(f) Short-term outpatient evaluative and crisis-intervention mental health services; 148 149

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction; 150 151

(h) Home health services; 152

(i) Prescription drug services; 153

(j) Nursing services; 154

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code; 155 156

(l) Physical therapy services; 157

(m) Chiropractic services; 158

(n) Any other category of services approved by the superintendent of insurance. 159 160

(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 161 162 163

mental illnesses on the same terms and conditions as other physical diseases and disorders. 164 165

(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. 166 167 168 169 170

(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. 171 172 173 174 175 176 177

(E) "Children's buy-in program" has the same meaning as in section 5101.5211 of the Revised Code. 178 179

(F) "Closed panel plan" means a health care plan that requires enrollees to use participating providers. 180 181

(G) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis. 182 183 184

(H) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation. 185 186 187

(I) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state. 188 189 190

(J) "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 191 192 193

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. 194 195 196 197

(K) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation. 198 199 200

(L) "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. 201 202 203 204

(M) "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. 205 206 207 208 209

(N) "Health care services" means basic, supplemental, and specialty health care services. 210 211

(O) "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. 212 213 214 215

(P) "Health insuring corporation" means a corporation, as defined in division (I) 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. 216 217 218 219 220 221 222 223 224

"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. 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245

(Q) "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. 246 247 248 249 250 251 252

(R) "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. 253 254 255 256

(S) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code. 257 258

(T) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment. 259 260 261

(U) "Medicare" means the program established under Title XVIII of the "Social Security Act" 49 Stat. 620 (1935), 42 U.S.C. 1395, as amended. 262 263 264

(V)(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. 265 266 267 268

(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. 269 270 271 272 273 274 275 276 277 278

(W) "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. 279 280 281 282

(X) "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. 283 284 285 286 287

(Y) "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. 288 289 290 291 292 293 294

(Z) "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. 295 296 297 298 299 300 301

(AA) "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. 302 303 304 305 306 307 308 309 310 311 312 313 314 315

(BB) "Provider sponsored organization" means a corporation, as defined in division (I) 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 316 317 318 319

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. 320 321 322 323 324 325 326 327

(CC) "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. 328 329 330 331

(DD) "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. 332 333 334 335 336

(EE) "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. 337 338 339 340 341 342 343 344

Sec. 1751.69. (A) As used in this section: 345

(1) "Equipment, supplies, and medication" includes both of the following, when determined to be medically necessary: 346 347

(a) Nonexperimental equipment, single-use medical supplies, and related devices approved by the United States food and drug 348 349

administration for the treatment and management of diabetes; 350

(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. 351 352 353 354

(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. 355 356 357 358 359

(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. 360 361 362 363 364 365 366 367 368

(B)(1) Notwithstanding section 3901.71 of the Revised Code, each individual or group health insuring corporation policy, contract, or agreement that covers basic health care services and is delivered, issued for delivery, or renewed in this state shall provide benefits for medical nutrition therapy and diabetes self-management education expenses, when determined to be medically necessary. 369 370 371 372 373 374 375

(2) Notwithstanding section 3901.71 of the Revised Code, each individual or group health insuring corporation policy, contract, or agreement that covers basic health care services and is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of medically necessary diabetes 376 377 378 379 380

medication, equipment, and supplies unless the insured person is covered by an employer-provided group supplemental benefit policy that provides comparable benefits for these expenses. Regardless of whether the benefits are provided through the policy, contract, or agreement that covers basic health care services or a supplemental benefit policy, the copayment and deductible amounts for the benefits shall not exceed those for other medication, equipment, and supplies for which benefits are provided by the policy, contract, or agreement. If the benefits are provided as part of the policy, contract, or agreement that covers basic health care services, the copayments and deductibles for the expenses shall be no higher than they would be if the benefits were provided through a supplemental benefit policy. 381 382 383 384 385 386 387 388 389 390 391 392 393

(C) All of the following apply to the provision of benefits for the expenses of diabetes self-management education and medical nutrition therapy: 394 395 396

(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. 397 398 399 400 401 402

(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. 403 404 405 406 407 408

(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 409 410 411 412

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. 413 414 415 416 417 418 419 420

(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. 421 422 423 424

(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. 425 426 427 428 429 430 431 432 433

(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: 434 435 436 437 438

(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 439 440 441 442 443 444

claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year. 445 446 447

(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. 448 449 450 451 452 453 454

(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: 455 456 457

(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. 458 459 460 461 462 463

(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. 464 465 466 467

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 468 469

Sec. 3923.71. (A) As used in this section: 470

(1) "Equipment, supplies, and medication" includes both of the following, when determined to be medically necessary: 471 472

(a) Nonexperimental equipment, single-use medical supplies, and related devices approved by the United States food and drug 473 474

administration for the treatment and management of diabetes; 475

(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. 476 477 478 479

(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. 480 481 482 483 484

(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. 485 486 487 488 489 490 491 492 493

(B)(1) Notwithstanding section 3901.71 of the Revised Code, each individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and each public employee benefit plan that is established or modified in this state, shall provide benefits for medical nutrition therapy and diabetes self-management education expenses, when determined to be medically necessary. 494 495 496 497 498 499 500

(2) Notwithstanding section 3901.71 of the Revised Code, each individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and each public employee benefit plan that is established or modified in this state, shall provide benefits for the expenses of 501 502 503 504 505

medically necessary diabetes medication, equipment, and supplies unless the insured person is covered by an employer-provided supplemental benefit policy that provides comparable benefits for these expenses. Regardless of whether the benefits are provided through the policy or plan, or a supplemental benefit policy, the copayment and deductible amounts for the benefits shall not exceed those for other medication, equipment, and supplies for which benefits are provided by the policy or plan. If the benefits are provided as part of the policy or plan, the copayments and deductibles for the expenses shall be no higher than they would be if the benefits were provided through a supplemental benefit policy. 506 507 508 509 510 511 512 513 514 515 516 517

(C) All of the following apply to the provision of benefits for the expenses of diabetes self-management education and medical nutrition therapy: 518 519 520

(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. 521 522 523 524 525 526

(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. 527 528 529 530 531 532

(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 533 534 535 536 537

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. 538 539 540 541 542 543 544

(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. 545 546 547 548

(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. 549 550 551 552 553 554 555 556 557

(D) An insurer or public employee benefit plan is not required to provide benefits for diabetes self-management education and medical nutrition therapy under this section if all of the following apply: 558 559 560 561

(1) The insurer or plan 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 insurer's or plan's costs for claims and administrative expenses for all covered services to increase by more than one per cent per year. 562 563 564 565 566 567 568 569

(2) The insurer or plan 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 insurer or plan for all covered services. 570 571 572 573 574 575 576

(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: 577 578 579

(a) Incurred claims for diabetes self-management education and medical nutrition therapy for a period of at least six months independently caused the insurer's or plan's costs for claims and administrative expenses for all covered services to increase by more than one per cent per year. 580 581 582 583 584

(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 or plan for the coverage of all covered services. 585 586 587

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 588 589

(E) This section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, medicare, tricare, long-term care, disability income, one-time limited duration policy of not longer than six months, or other policy that offers only supplemental benefits. 590 591 592 593 594 595 596

Section 2. That existing sections 1739.05 and 1751.01 of the Revised Code are hereby repealed. 597 598

Section 3. Section 1751.69 of the Revised Code shall apply 599

only to policies, contracts, and agreements that are delivered, issued for delivery, or renewed in this state on or after the effective date of this act; and section 3923.71 of the Revised Code shall apply to policies of sickness and accident insurance on or after the effective date of this act in accordance with section 3923.01 of the Revised Code and to plans that are established or modified in this state on or after the effective date of this act. 600 601 602 603 604 605 606

Section 4. (A) There is hereby created the Small Business Health Care Affordability Task Force. The Task Force shall commence its organizational meeting not later than thirty days after the effective date of this section. 607 608 609 610

(B)(1) The Task Force members shall consist of all of the following: 611 612

(a) Three members of the House of Representatives, two of whom are appointed by the Speaker of the House of Representatives and one of whom is appointed by the Minority Leader of the House of Representatives; 613 614 615 616

(b) Three members of the Senate, two of whom are appointed by the President of the Senate and one of whom is appointed by the Minority Leader of the Senate. 617 618 619

(2) The Task Force may, at its organizational meeting, appoint up to five additional members to the Task Force who represent small business employers or employees or who are otherwise relevant to the duties of the Task Force. A member appointed by the Task Force shall not be a member of the General Assembly. 620 621 622 623 624 625

(C) The Speaker of the House of Representatives and the President of the Senate shall each designate one member appointed under division (B)(1) of this section to serve as a co-chair of the Task Force. 626 627 628 629

(D) The Task Force shall do all of the following: 630

(1) Study the potential benefits of state tax incentives for small businesses that provide health insurance coverage for employees; 631 632 633

(2) Study potential state incentives for businesses to offer health wellness and disease prevention programs; 634 635

(3) Review employer health insurance tax incentives and wellness programs in other states and analyze whether such state policies would encourage greater affordability of employer-provided health insurance coverage and support employers in maintaining and expanding the workforce in Ohio; 636 637 638 639 640

(4) Consider federal legislation regarding the provision of health insurance by small businesses, including the proposed "Healthy Workforce Act of 2009" and "Small Business Health Options Program Act of 2009," and the potential impact of such federal legislation on Ohio's small businesses; 641 642 643 644 645

(5) Study the cost and feasibility of applying mandated health benefits as defined in section 3901.71 of the Revised Code to the Medicaid program. 646 647 648

(E) The Task Force shall report its findings and any recommendations to the Speaker of the House of Representatives, Minority Leader of the House of Representatives, President of the Senate, Minority Leader of the Senate, and Governor not later than six months following the initial organizational meeting of the Task Force. 649 650 651 652 653 654

(F) On submission of the report required under division (E) of this section, the Task Force shall cease to exist. 655 656

Section 5. Section 1751.01 of the Revised Code is presented in this act as a composite of the section as amended by both Am. Sub. H.B. 562 and Sub. S.B. 186 of the 127th General Assembly. The 657 658 659

General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.

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