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Representatives Celeste, Garland

Cosponsors: Representatives Okey, Harris, Dyer, Foley, Lundy, Harwood, Koziura, Stebelton, Hagan, Skindell, Stewart, Heard, Mallory, DeBose, Patten, Pryor, Yuko, Pillich, Newcomb, Murray, Phillips, Winburn, Letson, Bolon, Luckie, Williams, B., Slesnick, Moran, Belcher, Boyd, Brown, Chandler, Dodd, Domenick, Driehaus, Fende, Gerberry, Sykes, Szollosi, Ujvagi, Weddington, Yates

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A B I L L

To amend section 1739.05 and to enact sections 1
1751.68 and 3923.84 of the Revised Code to 2
prohibit health insurers from excluding coverage 3
for specified services for individuals diagnosed 4
with an autism spectrum disorder. 5

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

Section 1. That section 1739.05 be amended and sections 6
1751.68 and 3923.84 of the Revised Code be enacted to read as 7
follows: 8

Sec. 1739.05. (A) A multiple employer welfare arrangement 9
that is created pursuant to sections 1739.01 to 1739.22 of the 10
Revised Code and that operates a group self-insurance program may 11
be established only if any of the following applies: 12

(1) The arrangement has and maintains a minimum enrollment of 13
three hundred employees of two or more employers. 14

(2) The arrangement has and maintains a minimum enrollment of 15
three hundred self-employed individuals. 16

(3) The arrangement has and maintains a minimum enrollment of 17
three hundred employees or self-employed individuals in any 18
combination of divisions (A)(1) and (2) of this section. 19

(B) A multiple employer welfare arrangement that is created 20
pursuant to sections 1739.01 to 1739.22 of the Revised Code and 21
that operates a group self-insurance program shall comply with all 22
laws applicable to self-funded programs in this state, including 23
sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 24
to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 25
3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 26
3923.84, 3924.031, 3924.032, and 3924.27 of the Revised Code. 27

(C) A multiple employer welfare arrangement created pursuant 28
to sections 1739.01 to 1739.22 of the Revised Code shall solicit 29
enrollments only through agents or solicitors licensed pursuant to 30
Chapter 3905. of the Revised Code to sell or solicit sickness and 31
accident insurance. 32

(D) A multiple employer welfare arrangement created pursuant 33
to sections 1739.01 to 1739.22 of the Revised Code shall provide 34
benefits only to individuals who are members, employees of 35
members, or the dependents of members or employees, or are 36
eligible for continuation of coverage under section 1751.53 or 37
3923.38 of the Revised Code or under Title X of the "Consolidated 38
Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 39
U.S.C.A. 1161, as amended. 40

Sec. 1751.68. (A) Notwithstanding section 3901.71 of the 41
Revised Code, no health insuring corporation policy, contract, or 42
agreement that provides basic health care services that is 43
delivered, issued for delivery, or renewed in this state shall 44
exclude coverage for the screening and diagnosis of autism 45

spectrum disorders or for any of the following services when those 46
services are medically necessary and are prescribed, provided, or 47
ordered for an individual diagnosed with an autism spectrum 48
disorder by a health care professional licensed or certified under 49
the laws of this state to prescribe, provide, or order such 50
services: 51

(1) Habilitative or rehabilitative care; 52

(2) Pharmacy care if the policy, contract, or agreement 53
provides coverage for other prescription drug services; 54

(3) Psychiatric care; 55

(4) Psychological care; 56

(5) Therapeutic care; 57

(6) Counseling services; 58

(7) Any additional treatments or therapies adopted by the 59
director of mental retardation and developmental disabilities 60
pursuant to division (I)(4) of section 3923.84 of the Revised 61
Code. 62

(B) Coverage provided under this section shall be delineated 63
in a treatment plan developed by the attending psychologist or 64
physician and shall not be subject to any limits on the number or 65
duration of visits an individual may make to any autism service 66
provider, except as delineated in the treatment plan, if the 67
services are medically necessary. 68

(C) Coverage provided under this section may be subject to 69
any copayment, deductible, and coinsurance provisions of the 70
policy, contract, or agreement to the extent that other medical 71
services covered by the policy, contract, or agreement are subject 72
to those provisions. Coverage provided under this section may be 73
subject to a yearly maximum limitation of thirty-six thousand 74
dollars on claims paid for services related to coverage provided 75

under this section. 76

(D)(1) Not more than once every six months, a health insuring corporation may request a review of any treatment provided under this section unless the insured's licensed physician or licensed psychologist agrees that more frequent review is necessary. The health insuring corporation shall pay for any review requested under division (D)(1) of this section. 77
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(2) If requested by the health insuring corporation, the provider shall provide the health insuring corporation with an annual treatment plan. 83
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(3) Inpatient services are not subject to the six-month review limitations under division (D)(1) of this section. 86
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(E) This section shall not be construed as limiting benefits otherwise available under an individual's policy, contract, or agreement. 88
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(F) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan developed under 20 U.S.C. 1436 or individualized service plan developed under section 5126.31 of the Revised Code, or affecting the duty of a public school to provide a child with a disability with a free appropriate public education under the "Individuals with Disabilities Education Improvement Act of 2004," 20 U.S.C. 1400 et seq., as amended, and Chapter 3323. of the Revised Code. 91
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(G) A health insuring corporation that offers coverage for basic health care services is not required to offer the coverage required under division (A) of this section in combination with the offer of coverage for basic health care services if all of the following apply: 100
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(1) The health insuring corporation submits documentation certified by an independent member of the American academy of 105
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actuaries to the superintendent of insurance showing that incurred 107
claims for the coverage required under division (A) of this 108
section for a period of at least six months independently caused 109
the health insuring corporation's costs for claims and 110
administrative expenses for the coverage of all covered services 111
to increase by more than one per cent per year. 112

(2) The health insuring corporation submits a signed letter 113
from an independent member of the American academy of actuaries to 114
the superintendent of insurance opining that the increase in costs 115
described in division (G)(1) of this section could reasonably 116
justify an increase of more than one per cent in the annual 117
premiums or rates charged by the health insuring corporation for 118
the coverage of basic health care services. 119

(3) The superintendent of insurance makes both of the 120
following determinations from the documentation and opinion 121
submitted pursuant to divisions (G)(1) and (2) of this section: 122

(a) Incurred claims for the coverage required under division 123
(A) of this section for a period of at least six months 124
independently caused the health insuring corporation's costs for 125
claims and administrative expenses for the coverage of all covered 126
services to increase by more than one per cent per year. 127

(b) The increase in costs reasonably justifies an increase of 128
more than one per cent in the annual premiums or rates charged by 129
the health insuring corporation for the coverage of basic health 130
care services. 131

Any determination made by the superintendent under division 132
(G)(3) of this section is subject to Chapter 119. of the Revised 133
Code. 134

(H) The services covered under this section shall not be 135
considered supplemental health care services under division (B)(1) 136
of section 1751.01 of the Revised Code. 137

<u>(I) As used in this section:</u>	138
<u>(1) "Applied behavior analysis" means the design,</u>	139
<u>implementation, and evaluation of environmental modifications</u>	140
<u>using behavioral stimuli and consequences to produce socially</u>	141
<u>significant improvement in human behavior, including, but not</u>	142
<u>limited to, the use of direct observation, measurement, and</u>	143
<u>functional analysis of the relationship between environment and</u>	144
<u>behavior.</u>	145
<u>(2) "Autism services provider" means any person whose</u>	146
<u>professional scope of practice allows treatment of autism spectrum</u>	147
<u>disorders, whose services are delineated in the treatment plan</u>	148
<u>under division (B) of this section, and of whom one of the</u>	149
<u>following is true:</u>	150
<u>(a) The person is licensed, certified, or registered by an</u>	151
<u>appropriate agency of this state to perform the services assigned</u>	152
<u>to the person in the treatment plan.</u>	153
<u>(b) The person is directly supervised by an individual who is</u>	154
<u>licensed, certified, or registered by an appropriate agency of</u>	155
<u>this state to perform the services assigned to the person in the</u>	156
<u>treatment plan.</u>	157
<u>(3) "Autism spectrum disorder" means any of the pervasive</u>	158
<u>developmental disorders as defined by the most recent edition of</u>	159
<u>the diagnostic and statistical manual of mental disorders,</u>	160
<u>published by the American psychiatric association, or if that</u>	161
<u>manual is no longer published, a similar diagnostic manual. Autism</u>	162
<u>spectrum disorder includes, but is not limited to, autistic</u>	163
<u>disorder, Asperger's disorder, Rett's disorder, childhood</u>	164
<u>disintegrative disorder, and pervasive developmental disorder.</u>	165
<u>(4) "Diagnosis of autism spectrum disorders" means medically</u>	166
<u>necessary assessments, evaluations, or tests, including, but not</u>	167
<u>limited to, genetic and psychological tests to determine whether</u>	168

an individual has an autism spectrum disorder. 169

(5) "Habilitative or rehabilitative care" means professional, 170
counseling, and guidance services and treatment programs, 171
including applied behavior analysis, that are necessary to 172
develop, maintain, or restore the functioning of an individual to 173
the maximum extent practicable. 174

(6) "Medically necessary" means the service is based upon 175
evidence; is prescribed, provided, or ordered by a health care 176
professional licensed or certified under the laws of this state to 177
prescribe, provide, or order autism-related services in accordance 178
with accepted standards of practice; and will or is reasonably 179
expected to do any of the following: 180

(a) Prevent the onset of an illness, condition, injury, or 181
disability; 182

(b) Reduce or ameliorate the physical, mental, or 183
developmental effects of an illness, condition, injury, or 184
disability; 185

(c) Assist in achieving or maintaining maximum functional 186
capacity for performing daily activities, taking into account both 187
the functional capacity of the individual and the appropriate 188
functional capacities of individuals of the same age. 189

(7) "Pharmacy care" means prescribed medications and any 190
medically necessary health-related services used to determine the 191
need or effectiveness of the medications. 192

(8) "Psychiatric care" means direct or consultative services 193
provided by a psychiatrist licensed in the state in which the 194
psychiatrist practices psychiatry. 195

(9) "Psychological care" means direct or consultative 196
services provided by a psychologist licensed in the state in which 197
the psychologist practices psychology. 198

(10) "Therapeutic care" means services, communication devices, or other adaptive devices or equipment provided by a licensed speech-language pathologist, licensed occupational therapist, or licensed physical therapist. 199
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Sec. 3923.84. (A) Notwithstanding section 3901.71 of the Revised Code, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state or public employee benefit plan established or modified in this state shall exclude coverage for the screening and diagnosis of autism spectrum disorders or for any of the following services when those services are medically necessary and are prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order such services: 203
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(1) Habilitative or rehabilitative care; 214

(2) Pharmacy care if the policy, contract, or agreement provides coverage for other prescription drug services; 215
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(3) Psychiatric care; 217

(4) Psychological care; 218

(5) Therapeutic care; 219

(6) Counseling services; 220

(7) Any additional treatments or therapies adopted by the director of mental retardation and developmental disabilities pursuant to division (I)(4) of this section. 221
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(B) Coverage provided under this section shall be delineated in a treatment plan developed by the attending psychologist or physician and shall not be subject to any limits on the number or duration of visits an individual may make to any autism services provider, except as delineated in the treatment plan, if the 224
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services are medically necessary. 229

(C) Coverage provided under this section may be subject to 230
any copayment, deductible, and coinsurance provisions of the 231
policy or plan to the extent that other medical services covered 232
by the policy or plan are subject to those provisions. Coverage 233
provided under this section may be subject to a yearly maximum 234
limitation of thirty-six thousand dollars on claims paid for 235
services related to coverage provided under this section. 236

(D)(1) Not more than once every six months, an insurer or 237
public employee benefit plan may request a review of any treatment 238
provided under this section unless the insured's licensed 239
physician or licensed psychologist agrees that more frequent 240
review is necessary. The insurer or public employee benefit plan 241
shall pay for any review requested under division (D)(1) of this 242
section. 243

(2) If requested by the insurer or public employee benefit 244
plan, the provider shall provide the insurer or public employee 245
benefit plan with an annual treatment plan. 246

(3) Inpatient services are not subject to the six-month 247
review limitations under division (D)(1) of this section. 248

(E) This section shall not be construed as limiting benefits 249
otherwise available under an individual's policy or plan. 250

(F) This section shall not be construed as affecting any 251
obligation to provide services to an individual under an 252
individualized family service plan developed under 20 U.S.C. 1436 253
or individualized service plan developed under section 5126.31 of 254
the Revised Code, or affecting the duty of a public school to 255
provide a child with a disability with a free appropriate public 256
education under the "Individuals with Disabilities Education 257
Improvement Act of 2004," 20 U.S.C. 1400 et seq., as amended, and 258
Chapter 3323. of the Revised Code. 259

(G) 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. 260
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(H) A public employee benefit plan or insurer that offers a policy of sickness and accident insurance is not required to offer the coverage required under division (A) of this section if all of the following apply: 267
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(1) The insurer or public employee benefit plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year. 271
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(2) The insurer or public employee benefit 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 (H)(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 public employee benefit plan for the coverage of all covered services. 279
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(3) The superintendent of insurance makes both of the following determinations from the documentation and opinion submitted pursuant to divisions (H)(1) and (2) of this section: 286
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(a) Incurred claims for the coverage required under division (A) of this section for a period of at least six months 289
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independently caused the costs for claims and administrative 291
expenses for the coverage of all covered services to increase by 292
more than one per cent per year. 293

(b) The increase in costs reasonably justifies an increase of 294
more than one per cent in the annual premiums or rates charged by 295
the insurer or public employee benefit plan for the coverage of 296
all covered services. 297

Any determination made by the superintendent under division 298
(H)(3) of this section is subject to Chapter 119. of the Revised 299
Code. 300

(I)(1) The director of mental retardation and developmental 301
disabilities shall convene a committee on the coverage of autism 302
spectrum disorders to investigate and recommend treatments or 303
therapies for autism spectrum disorders that the committee 304
believes should be included in the services that health benefit 305
plans and public employee benefit plans are required to cover 306
under division (A) of this section and the qualifications of the 307
providers of those treatments or therapies. 308

(2) The committee shall consist of nine members appointed by 309
the director of mental retardation and developmental disabilities 310
including the director of mental retardation and developmental 311
disabilities, the director of health, at least one licensed 312
physician, licensed psychologist, and parent of an individual 313
diagnosed with an autism spectrum disorder. 314

(3) The committee shall serve at the pleasure of the 315
director. 316

(4) The committee shall submit its recommendations to the 317
director of mental retardation and developmental disabilities. The 318
director may adopt rules in accordance with Chapter 119. of the 319
Revised Code to include additional treatments or therapies for 320
autism spectrum disorders in the services that health benefit 321

plans and public employee benefit plans are required to cover 322
under division (A) of this section. 323

(J) As used in this section: 324

(1) "Applied behavior analysis" means the design, 325
implementation, and evaluation of environmental modifications 326
using behavioral stimuli and consequences to produce socially 327
significant improvement in human behavior, including, but not 328
limited to, the use of direct observation, measurement, and 329
functional analysis of the relationship between environment and 330
behavior. 331

(2) "Autism services provider" means any person whose 332
professional scope of practice allows treatment of autism spectrum 333
disorders, whose services are delineated in the treatment plan 334
under division (B) of this section, and of whom one of the 335
following is true: 336

(a) The person is licensed, certified, or registered by an 337
appropriate agency of this state to perform the services assigned 338
to the person in the treatment plan. 339

(b) The person is directly supervised by an individual who is 340
licensed, certified, or registered by an appropriate agency of 341
this state to perform the services assigned to the person in the 342
treatment plan. 343

(3) "Autism spectrum disorder" means any of the pervasive 344
developmental disorders as defined by the most recent edition of 345
the diagnostic and statistical manual of mental disorders, 346
published by the American psychiatric association, or if that 347
manual is no longer published, a similar diagnostic manual. Autism 348
spectrum disorder includes, but is not limited to, autistic 349
disorder, Asperger's disorder, Rett's disorder, childhood 350
disintegrative disorder, and pervasive developmental disorder. 351

(4) "Diagnosis of autism spectrum disorders" means medically 352

necessary assessments, evaluations, or tests, including, but not 353
limited to, genetic and psychological tests to determine whether 354
an individual has an autism spectrum disorder. 355

(5) "Habilitative or rehabilitative care" means professional, 356
counseling, and guidance services and treatment programs, 357
including applied behavior analysis, that are necessary to 358
develop, maintain, or restore the functioning of an individual to 359
the maximum extent practicable. 360

(6) "Health benefit plan" has the same meaning as in section 361
3924.01 of the Revised Code. 362

(7) "Medically necessary" means the service is based upon 363
evidence; is prescribed, provided, or ordered by a health care 364
professional licensed or certified under the laws of this state to 365
prescribe, provide, or order autism-related services in accordance 366
with accepted standards of practice; and will or is reasonably 367
expected to do any of the following: 368

(a) Prevent the onset of an illness, condition, injury, or 369
disability; 370

(b) Reduce or ameliorate the physical, mental, or 371
developmental effects of an illness, condition, injury, or 372
disability; 373

(c) Assist in achieving or maintaining maximum functional 374
capacity for performing daily activities, taking into account both 375
the functional capacity of the individual and the appropriate 376
functional capacities of individuals of the same age. 377

(8) "Pharmacy care" means prescribed medications and any 378
medically necessary health-related services used to determine the 379
need or effectiveness of the medications. 380

(9) "Psychiatric care" means direct or consultative services 381
provided by a psychiatrist licensed in the state in which the 382

psychiatrist practices psychiatry. 383

(10) "Psychological care" means direct or consultative 384
services provided by a psychologist licensed in the state in which 385
the psychologist practices psychology. 386

(11) "Therapeutic care" means services, communication 387
devices, or other adaptive devices or equipment provided by a 388
licensed speech-language pathologist, licensed occupational 389
therapist, or licensed physical therapist. 390

Section 2. That existing section 1739.05 of the Revised Code 391
is hereby repealed. 392

Section 3. Sections 1 and 2 of this act shall take effect 393
January 1, 2011. 394