

**As Introduced**

**129th General Assembly  
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**H. B. No. 376**

**Representatives Celeste, Garland**

**Cosponsors: Representatives Antonio, Ashford, Barnes, Boyd, Carney,  
Clyde, DeGeeter, Driehaus, Fedor, Fende, Foley, Gentile, Gerberry, Goyal,  
Hagan, R., Heard, Letson, Lundy, Mallory, Milkovich, Murray, O'Brien, Okey,  
Patmon, Phillips, Pillich, Ramos, Reece, Slesnick, Stinziano, Sykes, Szollosi,  
Weddington, Winburn, Yuko**

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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  
3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 26  
3923.80, 3923.84, 3924.031, 3924.032, and 3924.27 of the Revised 27  
Code. 28

(C) A multiple employer welfare arrangement created pursuant 29  
to sections 1739.01 to 1739.22 of the Revised Code shall solicit 30  
enrollments only through agents or solicitors licensed pursuant to 31  
Chapter 3905. of the Revised Code to sell or solicit sickness and 32  
accident insurance. 33

(D) A multiple employer welfare arrangement created pursuant 34  
to sections 1739.01 to 1739.22 of the Revised Code shall provide 35  
benefits only to individuals who are members, employees of 36  
members, or the dependents of members or employees, or are 37  
eligible for continuation of coverage under section 1751.53 or 38  
3923.38 of the Revised Code or under Title X of the "Consolidated 39  
Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 40  
U.S.C.A. 1161, as amended. 41

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

exclude coverage for the screening and diagnosis of autism 46  
spectrum disorders or for any of the following services when those 47  
services are medically necessary and are prescribed, provided, or 48  
ordered for an individual diagnosed with an autism spectrum 49  
disorder by a health care professional licensed or certified under 50  
the laws of this state to prescribe, provide, or order such 51  
services: 52

(1) Habilitative or rehabilitative care; 53

(2) Pharmacy care if the policy, contract, or agreement 54  
provides coverage for other prescription drug services; 55

(3) Psychiatric care; 56

(4) Psychological care; 57

(5) Therapeutic care; 58

(6) Counseling services; 59

(7) Any additional treatments or therapies adopted by the 60  
director of developmental disabilities pursuant to division (I)(4) 61  
of section 3923.84 of the Revised 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 services 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 opining that the increase in costs described in 115  
division (G)(1) of this section could reasonably justify an 116  
increase of more than one per cent in the annual premiums or rates 117  
charged by the health insuring corporation for the coverage of 118  
basic health care services. 119

(3) The superintendent makes both of the following 120  
determinations from the documentation and opinion submitted 121  
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 or plan 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 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. 260-266

(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: 267-270

(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. 271-278

(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 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. 279-285

(3) The superintendent makes both of the following determinations from the documentation and opinion submitted pursuant to divisions (H)(1) and (2) of this section: 286-288

(a) Incurred claims for the coverage required under division (A) of this section for a period of at least six months 289-290

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

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

(3) The committee shall serve at the pleasure of the 314  
director. 315

(4) The committee shall submit its recommendations to the 316  
director of developmental disabilities. The director may adopt 317  
rules in accordance with Chapter 119. of the Revised Code to 318  
include additional treatments or therapies for autism spectrum 319  
disorders in the services that health benefit plans and public 320  
employee benefit plans are required to cover under division (A) of 321

<u>this section.</u>	322
<u>(J) As used in this section:</u>	323
<u>(1) "Applied behavior analysis" means the design,</u>	324
<u>implementation, and evaluation of environmental modifications</u>	325
<u>using behavioral stimuli and consequences to produce socially</u>	326
<u>significant improvement in human behavior, including, but not</u>	327
<u>limited to, the use of direct observation, measurement, and</u>	328
<u>functional analysis of the relationship between environment and</u>	329
<u>behavior.</u>	330
<u>(2) "Autism services provider" means any person whose</u>	331
<u>professional scope of practice allows treatment of autism spectrum</u>	332
<u>disorders, whose services are delineated in the treatment plan</u>	333
<u>under division (B) of this section, and of whom one of the</u>	334
<u>following is true:</u>	335
<u>(a) The person is licensed, certified, or registered by an</u>	336
<u>appropriate agency of this state to perform the services assigned</u>	337
<u>to the person in the treatment plan.</u>	338
<u>(b) The person is directly supervised by an individual who is</u>	339
<u>licensed, certified, or registered by an appropriate agency of</u>	340
<u>this state to perform the services assigned to the person in the</u>	341
<u>treatment plan.</u>	342
<u>(3) "Autism spectrum disorder" means any of the pervasive</u>	343
<u>developmental disorders as defined by the most recent edition of</u>	344
<u>the diagnostic and statistical manual of mental disorders,</u>	345
<u>published by the American psychiatric association, or if that</u>	346
<u>manual is no longer published, a similar diagnostic manual. Autism</u>	347
<u>spectrum disorder includes, but is not limited to, autistic</u>	348
<u>disorder, Asperger's disorder, Rett's disorder, childhood</u>	349
<u>disintegrative disorder, and pervasive developmental disorder.</u>	350
<u>(4) "Diagnosis of autism spectrum disorders" means medically</u>	351
<u>necessary assessments, evaluations, or tests, including, but not</u>	352

limited to, genetic and psychological tests to determine whether 353  
an individual has an autism spectrum disorder. 354

(5) "Habilitative or rehabilitative care" means professional, 355  
counseling, and guidance services and treatment programs, 356  
including applied behavior analysis, that are necessary to 357  
develop, maintain, or restore the functioning of an individual to 358  
the maximum extent practicable. 359

(6) "Health benefit plan" has the same meaning as in section 360  
3924.01 of the Revised Code. 361

(7) "Medically necessary" means the service is based upon 362  
evidence; is prescribed, provided, or ordered by a health care 363  
professional licensed or certified under the laws of this state to 364  
prescribe, provide, or order autism-related services in accordance 365  
with accepted standards of practice; and will or is reasonably 366  
expected to do any of the following: 367

(a) Prevent the onset of an illness, condition, injury, or 368  
disability; 369

(b) Reduce or ameliorate the physical, mental, or 370  
developmental effects of an illness, condition, injury, or 371  
disability; 372

(c) Assist in achieving or maintaining maximum functional 373  
capacity for performing daily activities, taking into account both 374  
the functional capacity of the individual and the appropriate 375  
functional capacities of individuals of the same age. 376

(8) "Pharmacy care" means prescribed medications and any 377  
medically necessary health-related services used to determine the 378  
need or effectiveness of the medications. 379

(9) "Psychiatric care" means direct or consultative services 380  
provided by a psychiatrist licensed in the state in which the 381  
psychiatrist practices psychiatry. 382

(10) "Psychological care" means direct or consultative 383  
services provided by a psychologist licensed in the state in which 384  
the psychologist practices psychology. 385

(11) "Therapeutic care" means services, communication 386  
devices, or other adaptive devices or equipment provided by a 387  
licensed speech-language pathologist, licensed occupational 388  
therapist, or licensed physical therapist. 389

**Section 2.** That existing section 1739.05 of the Revised Code 390  
is hereby repealed. 391