**As Introduced**

**130th General Assembly**
**Regular Session** **H. B. No. 361**
**2013-2014**

**Representatives Gonzales, Smith**

**Cosponsor: Representative Landis**

# A B I L L

To amend section 1739.05 and to enact sections 1751.68, 3901.046, and 3923.591 of the Revised Code to prohibit health insurers from excluding coverage related to acquired brain injuries.

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

**Section 1.** That section 1739.05 be amended and sections 1751.68, 3901.046, and 3923.591 of the Revised Code be enacted to read as follows:

**Sec. 1739.05.** (A) 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 may be established only if any of the following applies:

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

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

(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.

(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, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.591, 3923.63, 3923.80, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(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.

(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.

**Sec. 1751.68.** (A) As used in this section:

(1) "Covered service" means any of the following services that the treating physician considers medically necessary as a result of or related to an acquired brain injury:

(a) Cognitive rehabilitation therapy;

(b) Cognitive communication therapy;

(c) Neurocognitive therapy and rehabilitation;

(d) Neurobehavioral, neurophysiological, neuropsychological,

and psychophysiological testing or treatment;

(e) Neurofeedback therapy;

(f) Remediation;

(g) Post-acute rehabilitation care treatment;

(h) Community reintegration services.

(2) "Acquired brain injury" means a brain injury caused by events occurring after birth.

(B) Notwithstanding section 3901.71 of the Revised Code, an individual or group health insuring corporation policy, contract, or agreement that provides basic health care services that is issued, delivered, or renewed in this state shall not exclude coverage for any covered service.

(C)(1) To ensure that appropriate post-acute rehabilitation care treatment is provided, an individual or group health insuring corporation policy, contract, or agreement shall include coverage for reasonable expenses related to periodic reevaluation of the care of an enrollee that:

(a) Has an acquired brain injury;

(b) Has been unresponsive to treatment; and

(c) Becomes responsive to treatment at a later date.

(2) Whether the expenses described in division (C)(1) of this section are reasonable may include consideration of any factor including:

(a) Cost;

(b) Time that has expired since the previous evaluation;

(c) Expertise of the physician or practitioner performing the evaluation;

(d) Changes in technology;

(e) Advances in medicine.

(D)(1) An individual or group health insuring corporation policy, contract, or agreement shall not deny coverage under this chapter for covered services solely because a service is provided at a facility other than a hospital. Covered services may be provided at any appropriate facility able to provide the services including all of the following:

(a) A hospital licensed under Chapter 3727. of the Revised Code, including an acute or post-acute rehabilitation hospital;

(b) A residential care facility licensed under Chapter 3721. of the Revised Code;

(c) A freestanding inpatient rehabilitation facility licensed under section 3702.30 of the Revised Code.

(2) The issuer of an individual or group health insuring corporation policy, contract, or agreement, including a preferred provider benefit plan or health maintenance organization plan, that contracts with or approves admission to a service provider's facility to provide covered services shall not refuse, solely because that facility is licensed as a residential care facility or freestanding inpatient rehabilitation center, to contract with or approve admission to that facility to provide covered services that are within the scope of the license of that facility and within the scope of the services provided under a rehabilitation program for acquired brain injury accredited by the commission on accreditation of rehabilitation facilities or another nationally recognized accreditation organization.

(3) The issuer of an individual or group health insuring corporation policy, contract, or agreement that requires or encourages enrollees to use health care providers designated by the plan shall ensure that covered services within the scope of a residential care facility's or freestanding inpatient

rehabilitation facility's license are made available and accessible to enrollees at an adequate number of residential care facilities or freestanding inpatient rehabilitation facilities.

(4) The issuer of an individual or group health insuring corporation policy, contract, or agreement shall not treat covered services as custodial care solely because the services are provided by a residential care facility if the facility has a rehabilitation program for acquired brain injury accredited by the commission on accreditation of rehabilitation facilities or another nationally recognized accreditation organization.

(5) To ensure the health and safety of enrollees, the superintendent may require that a residential care facility or freestanding inpatient rehabilitation facility that provides covered services through post-acute rehabilitation care treatment other than custodial care to an enrollee with an acquired brain injury has a rehabilitation program for acquired brain injury accredited by the commission on accreditation of rehabilitation facilities or another nationally recognized accreditation organization.

(E) An individual or group health insuring corporation policy, contract, or agreement that provides basic health care services that is issued, delivered, or renewed in this state is not required to provide benefits for covered services if all of the following apply:

(1) The issuer of the policy, contract, or agreement submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for covered services for a period of at least six months independently caused the issuer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The issuer of the policy, contract, or agreement submits a signed letter from an independent member of the American academy of actuaries to the superintendent opining that the increase from incurred claims for covered services could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the issuer for the coverage of all other physical diseases and disorders.

(3) The superintendent makes both of the following determinations from the documentation and opinion submitted under divisions (E)(1) and (2) of this section:

(a) Incurred claims for covered services for a period of at least six months independently caused the issuer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the issuer for the coverage of all other physical diseases and disorders.

(F) This section does not prohibit such coverage from being subject to the deductibles, copayments, and coinsurance prescribed under a health insuring corporation policy, contract, or agreement.

**Sec. 3901.046.** The superintendent shall adopt rules requiring health insuring corporations, sickness and accident insurers, multiple employer welfare arrangements, and public employee benefit plans to provide adequate training to personnel responsible for preauthorization of coverage or utilization reviews to prevent wrongful denial of the coverage required under sections 1751.68 and 3923.591 of the Revised Code and to avoid confusion of medical benefits with mental health benefits as they

pertain to these sections. Before adopting rules prescribing the basic requirements for the training described in this section, the superintendent shall consult with the brain injury advisory committee created in section 3304.241 of the Revised Code about those requirements.

**Sec. 3923.591.** (A) As used in this section, "covered service" and "acquired brain injury" have the same meanings as in section 1751.68 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, a policy of individual or group sickness and accident insurance that is issued, delivered, or renewed in this state, and each public employee benefit plan that is established or modified in this state, shall not exclude coverage for any covered service.

(C)(1) To ensure that appropriate post-acute rehabilitation care treatment is provided, a policy of individual or group sickness and accident insurance or a public employee benefit plan shall include coverage for reasonable expenses related to periodic reevaluation of the care of an insured that:

(a) Has an acquired brain injury;

(b) Has been unresponsive to treatment; and

(c) Becomes responsive to treatment at a later date.

(2) Whether the expenses described in division (C)(1) of this section are reasonable may include consideration of any factor including:

(a) Cost;

(b) Time that has expired since the previous evaluation;

(c) Expertise of the physician or practitioner performing the evaluation;

(d) Changes in technology;

(e) Advances in medicine.

(D)(1) A policy of individual or group sickness and accident insurance or a public employee benefit plan shall not deny coverage under this chapter for covered services solely because a service is provided at a facility other than a hospital. Covered services may be provided at any appropriate facility able to provide the services including all of the following:

(a) A hospital licensed under Chapter 3727. of the Revised Code, including an acute or post-acute rehabilitation hospital;

(b) A residential care facility licensed under Chapter 3721. of the Revised Code;

(c) A freestanding inpatient rehabilitation facility licensed under section 3702.30 of the Revised Code.

(2) The issuer of a policy of individual or group sickness and accident insurance or a public employee benefit plan, including a preferred provider benefit plan, that contracts with or approves admission to a service provider's facility to provide covered services shall not refuse, solely because that facility is licensed as a residential care facility or freestanding inpatient rehabilitation center, to contract with or approve admission to that facility to provide covered services that are within the scope of the license of that facility and within the scope of the services provided under a rehabilitation program for acquired brain injury accredited by the commission on accreditation of rehabilitation facilities or another nationally recognized accreditation organization.

(3) The issuer of a policy of individual or group sickness and accident insurance or a public employee benefit plan that requires or encourages insureds to use health care providers designated by the policy or plan shall ensure that covered

services within the scope of a residential care facility's or freestanding inpatient rehabilitation facility's license are made available and accessible to insureds at an adequate number of residential care facilities or freestanding inpatient rehabilitation facilities.

(4) The issuer of a policy of individual or group sickness and accident insurance or a public employee benefit plan shall not treat covered services as custodial care solely because the services are provided by a residential care facility if the facility has a rehabilitation program for acquired brain injury accredited by the commission on accreditation of rehabilitation facilities or another nationally recognized accreditation organization.

(5) To ensure the health and safety of insureds, the superintendent may require that a residential care facility or freestanding inpatient rehabilitation facility that provides covered services through post-acute rehabilitation care treatment other than custodial care to an insured with an acquired brain injury has a rehabilitation program for acquired brain injury accredited by the commission on accreditation of rehabilitation facilities or another nationally recognized accreditation organization.

(E) A policy or individual or group sickness and accident insurance or a public employee benefit plan that provides basic health care services that is issued, delivered, renewed, established, or modified in this state is not required to provide benefits for covered services if all of the following apply:

(1) The issuer of the policy 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 covered services for a period of at least six months independently caused the issuer's costs for claims and

administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The issuer of the policy or plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent opining that the increase from incurred claims for covered services could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the issuer for the coverage of all other physical diseases and disorders.

(3) The superintendent makes both of the following determinations from the documentation and opinion submitted under to divisions (E)(1) and (2) of this section:

(a) Incurred claims for covered services for a period of at least six months independently caused the issuer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the issuer for the coverage of all other physical diseases and disorders.

(F) This section does not prohibit such coverage from being subject to the deductibles, copayments, and coinsurance prescribed under a policy of sickness and accident insurance or a public employee benefit plan.

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

**Section 3.** Sections 1739.05 and 1751.68 of the Revised Code, as amended or enacted by this act, apply 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. Section 3923.591 of the Revised Code, as enacted by this act, applies only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state and public employee benefit plans that are established or modified in this state on or after the effective date of this act.