Katie Bentley *Legislative Service Commission*

Bill Analysis

H.B. 170

127th General Assembly
(As Introduced)

Reps. Celeste and Peterson, R. Hagan, Foley, Evans, Budish, Stebelton, Combs, Yuko, Skindell, Koziura, Lundy, Luckie

BILL SUMMARY

- Prohibits health insurers from excluding coverage for the diagnosis and treatment of autism.

CONTENT AND OPERATION

Coverage for autism

(secs. 1739.05, 1751.68, and 3923.80)

The bill prohibits policies, contracts, agreements, and plans of health insuring corporations, sickness and accident insurers, public employee benefit plans, and multiple employer welfare arrangements from excluding coverage for the diagnosis and treatment of autism.

A violation of the provisions of the bill is an unfair and deceptive practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code. Those sections specify additional unfair and deceptive practices and provide for administrative and legal remedies for violation through the Superintendent of Insurance and the Attorney General.

Definition of autism

(secs. 1751.68 and 3923.80)

The bill's definition of autism refers to the following definition of "autistic disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association:

(A) A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) Qualitative impairment in social interaction, as manifested by at least two of the following:

(a) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(b) Failure to develop peer relationships appropriate to developmental level;

(c) A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);

(d) Lack of social or emotional reciprocity.

(2) Qualitative impairments in communication as manifested by at least one of the following:

(a) Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime);

(b) In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;

(c) Stereotyped and repetitive use of language or idiosyncratic language;

(d) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

(3) Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;

(b) Apparently inflexible adherence to specific, nonfunctional routines or rituals;

(c) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);

(d) Persistent preoccupation with parts of objects.

(B) Delays or abnormal functioning in at least one of the following areas, with onset prior to age three years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

(C) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT**). Am. Sub. H.B. 478 of the 119th General Assembly provides that no mandated health benefits legislation enacted on or after January 14, 1993, can apply to any health benefits arrangement until the Superintendent of Insurance holds a public hearing and determines that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or its political subdivisions.[1] (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction.

COMMENT

Actuarial review

The benefits required by the bill may be considered "mandated benefits."[2] Pursuant to Sub. H.B. 405 of the 124th General Assembly, the chairperson of a standing committee of either house may, at any time, request that the Director of

[1] ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers that self-insure their benefit programs. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from an insurer or health insuring corporation.

[2] "Mandated benefit" means the following, considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement: (1) any required coverage for a specific medical or health-related service, treatment, medication, or practice, (2) any required coverage for the services of specific health care providers, (3) any requirement that an insurer or health insuring corporation offer coverage to specific individuals or groups, (4) any requirement that an insurer or health insuring corporation offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees, (5) any required expansion of, or addition to, existing coverage, and (6) any mandated reimbursement amount to specific health care providers (R.C. 103.144, not in the bill).

the Legislative Service Commission review any bill assigned to the chairperson's committee to determine whether the bill includes a mandated benefit. If the Director determines that the bill includes a mandated benefit, the presiding officer of the house that is considering the bill may request the Director to arrange for the performance of an independent healthcare actuarial review of the benefit. Not later than 60 days after the presiding officer's request for a review, the Director must submit the findings of the actuarial review to the chairperson of the committee to which the bill is assigned and to the ranking minority member of that committee. (R.C. 103.144 to 103.146, not in the bill.)

HISTORY

ACTION	DATE
Introduced	04-24-07

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