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Bill Analysis

H.B. 179

127th General Assembly
(As Introduced)

Rep. Blessing

BILL SUMMARY

- Requires a health insurer, if an employee has health insurance, during the time the employee's workers' compensation claim is pending, to pay for the services provided for the employee's workplace injury or occupational disease.

- Allows an employee, if the employee does not have health insurance, during the time the employee's workers' compensation claim is pending, to pay directly or to use the employee's medical savings account or health savings account to pay for the services provided for the employee's workplace injury or occupational disease.

- Specifies procedures for filing a workers' compensation claim and for payment of that claim under the bill.

- Requires a health insuring corporation or a sickness and accident insurer to cover a claim that may be covered under the Workers' Compensation Law during pendency of determination concerning that claim.

- Requires the Administrator of Workers' Compensation or a self-insuring employer, as applicable, to reimburse a health insurer or employee for expenses paid for a claim once it is deemed compensable.

- Requires the Administrator to adopt rules to establish methods to coordinate the provision and payment of medical benefits between health care providers, health insurers, and employees.

- Removes the Administrator's authority to limit choice of health care provider by charging out-of-plan copayments.

- Permits a health care provider to charge an employee a copayment or deductible for a potential workers' compensation claim if that copayment or deductible is part of the employee's health insurance policy.

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CONTENT AND OPERATION

Overview of the bill

Under Ohio's Workers' Compensation Law (R.C. Chapters 4121., 4123., 4127., and 4131.), compensable workers' compensation claims are paid either through the State Insurance Fund for employees of a state fund employer or directly by an employer to who the Administrator of Workers' Compensation has granted the privilege of self-insurance. Continuing law allows an employee or another person on behalf of an employee, to file a claim with the Bureau of Workers' Compensation (BWC) and specifies the timelines and procedures that BWC, the Administrator, and the Industrial Commission must follow in

processing a claim (sec. 4123.511). Under continuing law, medical benefits are not payable until the earlier of the date of the issuance of the staff hearing officer's order concerning a claim or the date of the final administrative or judicial determination of a claim (sec. 4123.511(I)).

The bill requires a health insurer and allows an employee, during the time an employee's workers' compensation claim is pending approval, to pay for services provided to care for an employee's workplace injury or occupational disease (sec. 4123.513). The bill requires the Administrator or a self-insuring employer, as appropriate, to reimburse that health insurer or employee for expenses they paid for the medical benefits provided in a claim once the claim is deemed compensable (secs. 4123.01, 4123.343, 4123.35, 4123.512, and 4123.513). Under the bill, a "health insurer" is a health insuring corporation holding a certificate of authority under the Health Insurance Corporation Law (R.C. Chapter 1751.) or an insurance company holding a certificate of authority issued under the Insurance Law (Title 39 of the Revised Code) (secs. 4121.01(A)(13) and 4123.01(J)). "Health insurance," under the bill, means a policy, contract, or agreement entered into between a subscriber and a health insuring corporation under the Health Insurance Corporation Law; a policy of sickness and accident insurance delivered, issued for delivery, renewed, or used pursuant to the Sickness and Accident Insurance Law (R.C. Chapter 3923.); or a high deductible health plan as defined under federal law (see **COMMENT** 1 and 2) (secs. 4121.01(A)(12) and (15) and 4123.01(J)).

Health insurance coverage

Insurance coverage under current law

Unless an exception applies, under continuing law all contracts and agreements are void that (1) undertake to indemnify or insure an employer against loss or liability for the payment of compensation to workers or their dependents for death, injury, or occupational disease occasioned in the course of the workers' employment or (2) provide that the insurer must pay the compensation, or which indemnify the employer against damages when the injury, disease, or death arises from the failure to comply with any lawful requirement for the protection of the lives, health, and safety of employees, or when the same is occasioned by the willful act of the employer or any of the employer's officers or agents, or by which it is agreed that the insurer must pay any such damages. Continuing law prohibits any public authority in Ohio from issuing any license or granting any authority to enter into any such agreements or to issue any such policies of insurance. (Sec. 4123.82.)

Under current law, a health insuring corporation policy, contract, or agreement, or a policy for sickness and accident insurance, must not be construed

to exclude an illness or an injury upon the ground that the subscriber or insured, as applicable, might have elected to have such illness or injury covered by workers' compensation under the Workers' Compensation Law unless the policy, contract, or agreement clearly excludes work or occupational related illness or injury, or the policy, contract, or agreement, or a separate writing signed by the subscriber or the insured, as applicable, informs the subscriber or the insured that such coverage is excluded and may be available to the subscriber or the insured under workers' compensation as the sole proprietor of a business, a member of a partnership, or an officer of a family farm corporation (secs. 1751.55 and 3923.36).

Insurance coverage under the bill

Under the bill, a health insurance contract, policy, or agreement that undertakes to provide coverage of medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, or other similar benefits for an injury or occupational disease that may be covered under the Workers' Compensation Law is not void provided that the contract, policy, or agreement includes a provision stating that coverage for that injury or occupational disease ceases once a final determination is made under continuing law stating that the claim is compensable under the Workers' Compensation Law. The bill states that nothing in the law declaring contracts that insure or indemnify workers' compensation claims void prohibits an employee from using the employee's health insurance or directly paying for medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, or other similar benefits for an injury the employee suffered or occupational disease the employee contracted. (Sec. 4123.82(B)(3) and (C).)

The bill also removes the ability of a health insuring corporation or a sickness or accident insurer to exclude an illness or injury on the grounds that the illness or injury may be covered under the Workers' Compensation Law if certain conditions are satisfied. Instead, under the bill, a health insuring corporation policy, contract, or agreement or a sickness and accident insurance policy must include coverage for an injury or occupational illness that may be covered under the Workers' Compensation Law in accordance with the procedures described under "***Payment of a claim while a final determination is pending***," below (see "***Exemption from H.B. 478 requirements***," below and **COMMENT** 3) (secs. 1751.55 and 3923.36).

The bill applies to all individual or group policies for sickness and accident insurance and all policies, contracts, or agreements between a subscriber and a health insuring corporation entered into on or after the bill's effective date (Section 4).

Health insuring corporations

Except as provided in continuing law, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers must seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles (sec. 1751.60(A)). The bill specifies that nothing in this provision must be construed to prevent a provider or facility from billing the Administrator after a final determination[1] is made that the subscriber or enrollee is eligible to receive compensation and benefits under the Workers' Compensation Law (sec. 1751.60(D)).

Sickness and accident insurance policies

Continuing law specifies provisions that a sickness and accident insurer must include in a sickness and accident insurance policy, including provisions regarding when an insured has "other valid coverage" that would cover the same loss that the sickness and accident insurance policy would cover of which the insurer did not have prior notice (sec. 3923.05(D) and (E)). An insurer, at the insurer's option, may include a definition of "other valid coverage" that is approved as to form by the Superintendent of Insurance, and if the insurer does not include a definition, continuing law specifies a definition. For the purpose of these provisions, current law specifies that any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, in all cases is deemed to be "other valid coverage" of which the insurer has had notice.

The bill specifies that "other valid coverage," whether defined by the insurer or statute, does not include compensation paid pursuant to Ohio's Workers' Compensation Law. However, the bill states that workers' compensation paid under federal law or another state's law is deemed to be other valid coverage of which the insurer has had notice. (Sec. 3923.05(D) and (E).)

[1] Under the bill, "final determination" means the later of the date that any of the following occur: (1) the decision by the Administrator, the Industrial Commission, or a court allowing compensation or benefits under the Workers' Compensation Law to an employee or an employee's dependents from which there is no further right to reconsideration or appeal that would require BWC or a self-insuring employer to withhold the payment of medical benefits, (2) the rights to reconsideration or appeal have expired without the employee or employer applying for reconsideration or appeal, (3) the application for reconsideration or appeal is withdrawn (sec. 4123.513(F)(1)).

Medical savings accounts

Ohio law specifies favorable tax treatment for medical savings accounts that a person establishes and uses in accordance with requirements specified in continuing law (secs. 3924.62 to 3924.74, not in the bill). A person may use funds from the person's medical savings account for an "eligible medical expense" as defined under continuing law. Currently, "eligible medical expense" does not include expenses otherwise paid or reimbursed under a workers' compensation insurance policy or plan or other specified insurance policies. The bill adds to the definition of eligible medical expense payments made pursuant to the bill (see "***Payment of a claim while a final determination is pending***," below) that may be subsequently reimbursed by the Administrator or a self-insuring employer. The bill excludes benefits otherwise paid or reimbursed under a federal or another state's workers' compensation policy or plan from the definition of eligible medical expense. (Sec. 3924.61(B).)

Procedure for filing a claim

Procedure under continuing law

Under current law, a claimant or another person, on behalf of a claimant, may file a workers' compensation claim with BWC. Continuing law requires BWC, within seven days after receipt of any claim, to notify the claimant and the employer of the claimant of the receipt of the claim and of the facts alleged therein. If BWC receives from a person other than the claimant information indicating that an injury or occupational disease has occurred or been contracted that may be compensable under the Workers' Compensation Law, BWC must notify the employee and the employer of the information. Except as otherwise provided in the Workers' Compensation Law and for claims in which the employer is a self-insuring employer, if the Administrator determines that a claimant is or is not entitled to an award of compensation or benefits, the Administrator must issue an order no later than 28 days after sending the notice described above, that grants or denies the payment of the compensation or benefits, or both as is appropriate. (Sec. 4123.511(A) and (B).) The claimant or the employer may appeal the decision in accordance with procedures set forth in continuing law. The Workers' Compensation Law sets forth timelines for which appeals may filed with the Industrial Commission and the courts and sets forth timelines within which district hearing officers, staff hearing officers, and the Industrial Commission must make decisions (secs. 4123.511 and 4123.512).

Continuing law permits the Administrator, with the advice and consent of the Workers' Compensation Oversight Commission, to adopt rules that identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The Administrator may grant immediate allowance

of any medical condition identified in those rules upon the filing of a claim involving that medical condition and may make immediate payment of medical bills for any medical condition identified in those rules that is included in a claim. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, payment for the medical condition included in that claim is charged to and paid from the Surplus Fund. (Sec. 4123.511(A).)

Additional procedures under the bill

Under the bill, if a health care provider provides services to an employee who suffers an injury or contracts an occupational disease that may be compensable under the Workers' Compensation Law and the employee has health insurance, the health care provider must submit a claim to the employee's health insurer and include a statement with the claim that the employee's injury or occupational disease may be compensable under the Workers' Compensation Law. Within three days after receiving such a claim from a health care provider, the health insurer must file a claim with BWC regarding the alleged injury or occupational disease (sec. 4123.511(A)).

If a health care provider provides services to an employee who suffers an injury or contracts an occupational disease that may be compensable under the Workers' Compensation Law and the employee does not have health insurance, the health care provider, employee, or employer must file a claim with BWC regarding the alleged injury or occupational disease (sec. 4123.511(A)). Under the bill, the procedures specified under "***BWC procedure under continuing law***," above apply once BWC receives a claim.

Payment of a claim while a final determination is pending

For all claims filed on or after the bill's effective date, during the time period in which an employee's workers' compensation claim is pending after the initial filing of the claim or during the appeals process, the bill requires an employee who suffers an injury or who contracts an occupational disease to use the employee's health insurance to pay the medical bills for the services provided to care for the injury or occupational disease. If the employee does not have health insurance, the bill allows the employee to pay those medical bills directly. An employee may use the employee's health savings account or medical savings account to pay any medical bills accrued in the claim (sec. 4123.513(A) and Section 3).

Payments by an employee who has health insurance

The bill requires a health care provider to submit all medical bills that accrue as a result of that injury or occupational disease to the employee's health insurer for reimbursement until the health care provider receives the notice described under "***Notification of final determination from BWC***," below, that the employee is eligible to receive compensation and benefits under the Workers' Compensation Law (sec. 4123.513(A)(1)). The employee's health insurer must pay all medical bills that the health insurer receives for that injury or occupational disease in accordance with the employee's health insurance policy, contract, or agreement unless the health insurer receives that notice (see "***Exemption from H.B. 478 requirements***," below and **COMMENT** 3). The health insurer must maintain copies of all medical bills the health insurer pays for treatment of that injury or occupational disease. (Sec. 4123.513(A)(1).)

The bill permits a health care provider to bill an employee directly for any services rendered for that employee's injury or occupational disease that are not covered by the employee's health insurance policy, contract, or agreement. A health care provider may charge or assess the employee a copayment in accordance with the provisions of the employee's health insurance policy, contract, or agreement. If the employee pays any medical bill, copayments, or any part of a deductible, the employee must maintain copies of all those medical bills, copayments, or parts of a deductible the employee paid. (Sec. 4123.513(A)(1).)

Payments by an employee who does not have health insurance or who has a health savings account or medical savings account

If an employee does not have health insurance and the health care provider elects to bill the employee directly and the employee elects to pay those bills, the bill requires the employee to maintain copies of all medical bills the employee paid for that injury or occupational disease. If an employee uses funds from a health savings account or a medical savings account to pay for any medical bills for services rendered for the employee's injury or occupational disease, the employee must maintain copies of those bills and indicate on those copies that the employee used funds from a health savings account or medical savings account to pay for those bills. (Sec. 4123.513(A)(2) and (3).)

Notification of final determination from BWC

Within five days after a final determination is made concerning an employee's eligibility to receive compensation and benefits under the Workers' Compensation Law for the employee's injury or occupational disease pursuant to continuing law, the Administrator must send to the employer, the employee, the

employee's health insurer, if applicable, and the employee's health care provider the appropriate written notice described below (sec. 4123.513(B)).

If employee is not eligible

If a final determination is made that an employee is not eligible to receive compensation and benefits under the Workers' Compensation Law for that injury or occupational disease, the bill requires the Administrator to include all of the following statements in a written notice:

- The employee is ineligible to receive workers' compensation and benefits for the employee's injury or occupational disease.

- The health care provider must continue billing the health insurer or employee, as applicable, for services rendered by that health care provider to treat the employee's injury or occupational disease.

- If a health insurer is covering the service rendered by a health care provider for the employee's injury or occupational disease, the health insurer must continue providing coverage in accordance with the provisions of the employee's health insurance policy, contract, or agreement. (Sec. 4123.513(B)(1).)

If an employee is eligible

Under the bill, if a final determination is made that the employee is eligible to receive compensation and benefits under the Workers' Compensation Law for the employee's injury or occupational disease, the Administrator must include all of the following statements in a written notice:

- The employee is eligible to receive workers' compensation and benefits for the employee's injury or occupational disease.

- The health care provider must cease billing the employee's health insurer or employee and must submit all bills for that employee's injury or occupational disease with a date of service on or after the date that the final determination is made, to the Administrator, or if the employee's employer is a self-insuring employer, to the employer, for payment.

- If a health insurer paid a health care provider for services rendered for that claim prior to the date that the final determination is made, the health insurer must submit copies of all invoices paid by the health insurer for that claim to the Administrator, or if the employee's

employer is a self-insuring employer, to the employer, and include the employee's claim number on each copy of an invoice that the health insurer submits.

- If an employee paid any medical bills, copayments, or part of a deductible, or used a health savings account or medical savings account to pay a bill, the employee must submit copies of all bills paid to the Administrator or, if the employee's employer is a self-insuring employer, to the employer, and must include the employee's claim number on each copy of a bill that the employee submits. (Sec. 4123.513(B)(2).)

Reimbursement of bills paid

Beginning on the date that a final determination is made that an employee is eligible to receive compensation or benefits under the Worker's Compensation Law, the bill requires the Administrator or self-insuring employer, as appropriate, to commence payment of the medical bills for that employee's claim (sec. 4123.513(E)). Except if an employee used funds from a health savings account or medical savings account to make payments for a claim, upon receipt of the copies of medical bills paid by a health insurer or employee, the Administrator, or the employee's employer, if the employee's employer is a self-insuring employer, must reimburse the health insurer or the employee for any medical bill the health insurer or employee paid for that claim on the condition that the services rendered for that medical bill are compensable under the Workers' Compensation Law. The bill requires the Administrator or self-insuring employer, as appropriate, also to reimburse an employee for any copayments and any part of a deductible that the employee paid for that compensable claim. (Sec. 4123.513(C).) Upon receipt of a copy of a medical bill from an employee that indicates that the employee used funds from a health savings account or medical savings account to pay that bill, the Administrator or self-insuring employer, as appropriate, must send the reimbursement for that bill to the trustee or custodian of the health savings account or medical savings account, who must deposit the reimbursement in the employee's health savings account or medical savings account, as applicable, on behalf of the employee. The Administrator or self-insuring employer must reimburse only those bills that are compensable under the Workers' Compensation Law (sec. 4123.513(D)).

Continuing law specifies conditions for the use of the funds in the State Insurance Fund and specifies that the funds that remain after those conditions are satisfied constitute a trust fund for the benefit of employers and employees for the payment of compensation, medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, rehabilitation, death benefits, funeral expenses, and like benefits for loss sustained on account of

injury, disease, or death provided for by the Workers' Compensation Law, and for no other purpose. The bill adds that the State Insurance Fund may be used for reimbursements to health insurers and employees for bills for medical benefits that the health insurer or employee paid pursuant to the bill. (Sec. 4123.30.)

Timing of payments

Continuing law specifies payment dates for the payment of equipment, materials, supplies, and goods purchased by a state agency (sec. 126.30). In applying the continuing law requirements to invoices submitted to BWC for equipment, materials, goods, supplies, or services provided to employees in connection with an employee's claim for compensation for injuries or occupational disease pursuant to the Workers' Compensation Law, the required payment date is the date on which payment is due under the terms of a written agreement between BWC and the provider. If a specific payment date is not established by a written agreement, the required payment date is 30 days after BWC receives a proper invoice, as defined under continuing law, for the amount of the payment due or 30 days after the final adjudication allowing payment of an award to the employee, whichever is later. Continuing law states that nothing in this provision supersedes any faster timetable for payments to health care providers contained in laws governing the Health Partnership Program, the Qualified Health Plan System, or the appeals process under the Workers' Compensation Law.

The bill adds to the specific payment dates described above that if a health insurer or an employee submits the invoice to the Administrator pursuant to the bill (see "***Payment of a claim while BWC decision pending***," above), the required payment date is 30 days after the Administrator receives a proper invoice for the amount of the payment due or 30 days after the final adjudication allowing payment of an award to the employee, whichever is later. (Sec. 126.30(D).)

Under continuing law BWC must follow a specified procedure to notify a health care provider about a defect in the invoice the health care provider submitted to BWC if BWC determines that a defect exists prior to a final adjudication (sec. 126.30(D)). The bill specifies that if after a final adjudication a health insurer or employee submits a copy of an invoice to the administrator under the bill and the Administrator determines that the invoice contains a defect, the Administrator must notify the health insurer or employee in writing at least 15 days prior to what would be the required payment date if the invoice did not contain a defect. The notice must contain a description of the defect and any additional information necessary to correct the defect. If the Administrator sends a notification to the health insurer or employee, the required payment date must be redetermined in accordance with the procedures for determining the payment date under continuing law after the Administrator receives a proper invoice.

The bill also changes references to the BWC to the "Administrator" instead throughout this provision. (Sec. 126.30(D).)

Choice of health care providers

Continuing law requires the Administrator to direct the implementation of the Health Partnership Program (HPP) administered by BWC to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under the Workers' Compensation Law (secs. 4121.44 and 4121.441). Additionally, continuing law requires the Administrator to oversee the implementation of the Qualified Health Plans (QHP), which are plans that a self-insuring employer or a state fund employer may develop to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under the Workers' Compensation Law (secs. 4121.44 and 4121.442). Current law permits the Administrator, as part of the HPP, to limit freedom of choice of health care provider or supplier by requiring that claimants pay an appropriate out-of-plan copayment for selecting a medical provider not within the HPP (sec. 4121.44(F)). Current law also states, in areas outside the state or within the state where no QHP or an inadequate number of providers within the HPP exist, that the Administrator must permit employees to use a nonplan or nonprogram health care provider and must pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease that is compensable under the Workers' Compensation Law on a fee schedule the Administrator adopts (sec. 4121.44(J)).

The bill removes the authority of the Administrator to limit the choice of health care provider by requiring claimants to pay a copayment for selecting a medical provider outside the HPP. Additionally, the bill removes the requirement that the Administrator allow employees to use a nonplan or nonprogram health care provider when no QHP providers or a limited number of HPP providers are present (sec. 4121.44(F) and (J)). The bill requires the Administrator, when adopting standards for the QHP, to authorize employees to select a health care provider who is not included in the employer's qualified plan if the employee is receiving services from that health care provider pursuant to the bill (see "***Payment of a claim while a final determination is pending***," above) (sec. 4121.442(A)(5)).

Continuing law prohibits a health care provider from charging, assessing, or otherwise attempting to collect from an employee, employer, a managed care organization, or BWC any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, BWC, or a QHP (sec. 4121.44(K)). The bill adds an exception to this prohibition and allows a health care provider to charge or assess an employee a copayment or deductible

in accordance with the procedures specified under "***Payment of a claim while a final determination is pending***," above (sec. 4121.44(I)).

Coordination of providing medical benefits

The bill requires the Administrator, in adopting rules for the HPP and standards for the QHP, to do all of the following:

(1) Establish methods to coordinate benefits provided by a health care provider when a health insurer or employee is paying the bills incurred in a claim pursuant to the procedures described under "***Payment of a claim while a final determination is pending***," above and prior to a final determination of the employee's eligibility to receive workers' compensation benefits under continuing law (secs. 4123.511 or 4123.512);

(2) Establish methods to determine the amount a health insurer or employee must pay a health care provider for medical bills incurred in the employee's claim prior to a final determination of the employee's eligibility to receive workers' compensation benefits under continuing law;

(3) Establish methods to determine the amount a health care provider is paid after a final determination has been made concerning an employee's eligibility to receive compensation and benefits under the Workers' Compensation Law;

(4) Establish methods to determine the amount BWC must reimburse a health insurer or employee for payment of medical bills for a claim after a final determination has been made that the employee is eligible to receive compensation and benefits under the Workers' Compensation Law (secs. 4121.441(A)(13) to (16) and 4121.442(A)(15) to (18)).

Additional insurance law changes

Current law requires every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage to cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services. Current law specifies several exceptions to this requirement, including insurance arising out of workers' compensation or similar law or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. (Sec. 3923.65.)

Under continuing law, the Superintendent of Insurance must establish and maintain (1) a system for receiving and reviewing requests for review from insureds who have been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the insured's policy or certificate and (2) a system for receiving and reviewing requests for review from plan members who have been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the public employee benefit plan. Several types of insurance plans, including insurance arising out of workers' compensation or similar law or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, are exempt from these review systems.

The bill removes the exemption from the emergency medical coverage requirements and the review systems described above for insurance claims arising under Ohio's Workers' Compensation Law, but maintains those exemptions for insurance arising out of federal or another state's workers' compensation or similar law. (Secs. 3923.65(D), 3923.66, and 3923.75.)

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT** 3). 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.[2] (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction.

[2] 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.

COMMENT

1. ***Health savings accounts***

Health savings accounts (HSA) enjoy favorable tax treatment under current federal and Ohio income tax law.[3] A person must be an eligible individual to receive these benefits. To qualify as an eligible individual, an employee may not be simultaneously covered under any health plan other than a high deductible health plan or by any other plan providing the same kind of coverage,[4] may not be enrolled in Medicare, and may not be claimed as a dependent on another person's tax return. HSAs may cover the eligible individual, the individual's spouse, and dependents.

An individual's contributions to the individual's HSA are tax deductible up to a maximum set by federal law. Money in an HSA, including interest or other earnings accreting to balances in the account, becomes taxable only if it is used for any purpose other than paying "qualified medical expenses" as defined in federal law. If money is withdrawn and used for any purpose other than a qualifying medical expense, federal law imposes an additional tax penalty of 10% of the sum withdrawn unless the account holder dies, is 65 years of age or older, or is disabled. There is no additional Ohio penalty on the withdrawn sum.

To qualify for an HSA and to be an eligible individual, a person must have a high deductible health plan. A high deductible health plan must have an annual deductible of at least $1,050 for single coverage or $2,100 for family coverage. The sum of the annual deductible and out-of-pocket expenses may not exceed $5,250 (single) and $10,500 (family).[5] The deductible or out-of-pocket maximum expenses may be higher if the plan uses a network of providers and a higher

[3] The favorable Ohio tax treatment results from the Ohio income tax base being equal to federal adjusted gross income (FAGI), which reflects the HSA deduction. The federal deduction therefore is incorporated into the Ohio tax base, as evidenced by the fact that the Ohio income tax form adopts FAGI without requiring any offsetting adjustment to add back HSA contributions or interest. The implicit incorporation of the HSA deduction presumably arises from unrelated amendments to the relevant section of law (R.C. 5747.01) after the federal HSA deduction was enacted.

[4] Some kinds of coverage are not disqualifying, including accident coverage, disability, dental, vision, long-term care, workers' compensation, property-related coverages, insurance for a specific illness or disease, or insurance paying a per diem for hospitalization.

[5] These dollar figures are for 2006; they are adjusted annually according to an inflation index.

deductible or out-of-pocket maximum is higher for non-network providers. (Secs. 4121.01(A)(15)(a) and 4123.513, 26 U.S.C. § 223, and U.S. Internal Revenue Service, Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, *available at* http://www.irs.gov/pub/irs-pdf/p969.pdf, last visited May 14, 2007.)

2. ***Medical savings accounts***

A medical savings account (MSA) is a federally tax-exempt trust or custodial account used for future tax expenses. MSAs have tax benefits under Ohio law as well (R.C. 3924.61 to 3924.74). Only an employee of a small employer that maintains a high deductible health plan or persons who are self-employed and have a high deductible health plan may use an MSA. Those persons cannot be covered under any other health plan except for specified insurance plans, including workers' compensation. Similar to HSAs, MSAs are tax exempt under federal law. Distributions from an MSA are taxable if the money is used for any purpose other than for qualified medical expenses as defined under federal law. There is a 15% additional tax under federal law on distributions not used for qualified medical expenses. There does not appear to be an additional Ohio penalty on the distributed sum.

To qualify for an MSA and to be an eligible individual, a person must have a high deductible health plan. In general, a high deductible health plan is a plan that (1) in the case of self-only coverage, has an annual deductible that is not less than $1,800 and not more than $2,700 and the annual out-of-pocket expenses required to be paid under the plan, other than for premiums for covered benefits, does not exceed $3,650 for self-only coverage, or (2) in the case of family coverage, that has an annual deductible that is not less than $3,650 and not more than $5,450, and the annual out-of-pocket expenses required to be paid under the plan, other than for premiums, for covered benefits does not exceed $6,650 for family coverage. (Secs. 4121.12(A)(15)(b) and 4123.513, 26 U.S.C. § 220, and U.S. Internal Revenue Service, Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, *available at* http://www.irs.gov/pub/irs-pdf/p969.pdf, last visited May 14, 2007.)

3. Actuarial review

The benefits required by the bill may be considered "mandated benefits."[6] Pursuant to Sub. H.B. 405 of the 124th General Assembly, the chairperson of a

[6] "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

standing committee of either house may, at any time, request that the Director of 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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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).