Alan Van Dyne *Legislative Service Commission*

Bill Analysis

Sub. H.B. 493

127th General Assembly
(As Reported by S. Health, Human Services, & Aging)

Reps. Daniels, Ujvagi, Flowers, Goodwin, Collier, Zehringer, Strahorn, J. Otterman, R. Hagan, Budish, Chandler, Combs, Domenick, Evans, Gerberry, Harwood, Letson, Szollosi

Sens. Wagoner, Seitz

BILL SUMMARY

ANATOMIC PATHOLOGY SERVICES

- Prohibits a clinical laboratory or physician from presenting, or causing to be presented, a claim, bill, or demand for payment for anatomic pathology services to anyone other than the following: the patient or other person responsible for the patient's bills, the patient's insurer or other third-party payor, a hospital or clinic that orders the services, a referring clinical laboratory, a governmental agency or person acting on the agency's behalf, or a physician who is otherwise authorized to bill for the services.

- Prohibits a physician from charging, billing, or otherwise soliciting payment for anatomic pathology services unless the services are personally rendered by the physician or rendered under the on-site supervision of the physician.

- Permits a physician who performs the professional component of an anatomic pathology service to bill for the amount incurred in (1) having the technical component performed by a clinical laboratory or another physician or (2) obtaining another physician's consultation.

- Permits a physician to bill for having an anatomic pathology service performed on a dermatology specimen, but only if the billing physician discloses (1) the name and address of the clinical laboratory or physician who performed the service and (2) the amount the billing physician was charged or paid for the service.

- Specifies that the bill's prohibitions are not to be construed to mandate the assignment of benefits for anatomic pathology services.

- Authorizes the State Medical Board to take disciplinary action against a physician who violates the bill's prohibitions pertaining to physicians.

HEALTH BENEFIT PLANS

- Exempts the mandate that a health benefit plan or public employee benefit plan cover the costs of routine patient care administered to an insured participating in an eligible cancer clinical trial from a requirement that the Superintendent of Insurance, before the mandate is enforced, make a determination that it can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and employee benefit plans established or modified by the state or a political subdivision of the state.

- Eliminates a requirement that a policy of sickness and accident insurance that excludes coverage of loss resulting from use of intoxicants or narcotics contain a provision providing that the insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

- Prohibits any health benefit plan or public employee benefit plan from containing a provision that limits or excludes any insured's coverage under the plan for a loss or expense the insured sustains that is the result of the insured's use of alcohol or other drugs or both if the loss or expense is otherwise covered under the plan.

- Provides that this prohibition is not to be construed as (1) requiring coverage for the treatment of alcohol or substance abuse except as otherwise required by law or (2) prohibiting the enforcement of an exclusion based on injuries sustained by an insured during the commission of an offense by the insured in which the insured is convicted of or pleads guilty or no contest to a felony.

HEALTH CARE CONTRACTS

- Extends to three years, from two, the period of time prohibitions regarding most favored nation clauses in health care contracts are to be in effect, other than such prohibitions concerning health care contracts with hospitals.

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CONTENT AND OPERATION

ANATOMIC PATHOLOGY SERVICES

Restrictions on billing for anatomic pathology services

The bill establishes restrictions regarding billing for anatomic pathology services. "Anatomic pathology services" is defined as all of the following:

(1) Histopathology or surgical pathology--the gross and microscopic examination and histologic processing[1] of organ tissue performed by a physician or under the supervision of a physician (R.C. 3701.86(F)).

[1] The bill defines "histologic processing" as fixation, processing, embedding, microtomy, and other special staining, including histochemical or immunohistochemical staining and in situ hybridization of clinical human tissues or cells, for pathological examination (R.C. 3701.86(F)).

(2) Cytopathology--the microscopic examination of cells from fluids, aspirates, washings, brushings, or smears, including a Papanicolau smear (PAP smear or test) (R.C. 3701.86(D)).

(3) Hematology--the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist (R.C. 3701.86(E)).

(4) Subcellular or molecular pathology--the assessment of a patient specimen for the detection, localization, measurement, or analysis of one or more protein or nucleic acid targets performed or interpreted by or under supervision of a pathologist (R.C. 3701.86(K)).

(5) Blood banking services performed by pathologists.

Entities that may be billed by clinical laboratories and physicians

(R.C. 3701.861(A) and 4731.72(B))

The bill prohibits a clinical laboratory[2] or physician, including a podiatrist,[3] from presenting, or causing to be presented, a claim, bill, or demand for payment for anatomic pathology services to any person or entity other than the following:

(1) The patient who receives the services or another individual, such as a parent, spouse, or guardian, who is responsible for the patient's bills;

(2) A responsible insurer[4] or other third-party payor of a patient who receives the services;

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[2] The bill defines a "clinical laboratory" as a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of substances derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or in the assessment or impairment of the health of human beings (R.C. 3701.86(C)).

[3] The bill defines "physician" as an individual authorized by the State Medical Board to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery (R.C. 3701.86(I)).

[4] The bill defines an "insurer" as a person authorized to engage in the business of insurance in Ohio, a health insuring corporation, or an entity that is self-insured and provides benefits to its employees or members (R.C. 3701.86(H)).

(3) A hospital, public health clinic, or not-for-profit health clinic ordering the services;

(4) A referring clinical laboratory;[5]

(5) A governmental agency or any person acting on behalf of a governmental agency;

(6) A physician who, under the bill, is permitted to bill for the services.

With respect to clinical laboratories, the bill specifies that this prohibition does not prohibit a clinical laboratory that provides anatomic pathology services from billing a referring clinical laboratory for anatomic pathology services in instances in which the referring clinical laboratory sends one or more samples to the clinical laboratory for purposes of having a specialist perform analysis, consultation, or histologic processing.

Services billed by physicians to be personally rendered or supervised

(R.C. 4731.72(C))

The bill generally prohibits a physician from charging, billing, or otherwise soliciting payment, directly or indirectly, for anatomic pathology services unless the services are personally rendered by the physician or rendered under the on-site supervision of a physician.

Billing by physicians for consultations and technical services

(R.C. 4731.72(D)(1))

The bill permits a physician who performs the professional component[6] of an anatomic pathology service on a patient specimen to bill for the amount incurred in doing either of the following:

[5] The bill defines a "referring clinical laboratory" as a clinical laboratory that refers a patient specimen to another clinical laboratory for an anatomic pathology service, but excludes a laboratory in an office of one or more physicians that refers a specimen and does not perform the professional component of the anatomic pathology service (R.C. 3701.86(J)).

[6] The bill specifies that the professional component of an anatomic pathology service means the entire anatomic pathology service other than histologic processing (R.C. 4731.72(A)(2)).

(1) Having a clinical laboratory or another physician perform the technical component of the service;[7]

(2) Obtaining another physician's consultation regarding the patient specimen.

Billing by physicians relative to dermatology specimens

(R.C. 4731.72(D)(2))

The bill permits a physician to bill for having a clinical laboratory or another physician perform an anatomic pathology service on a dermatology specimen, but only if the billing physician discloses to the person or entity being billed both of the following:

(1) The name and address of the clinical laboratory or physician who performed the service;

(2) The amount the billing physician was charged by or paid to the clinical laboratory or physician who performed the service.

Assignment of benefits

(R.C. 3701.86, 3701.861(B), and 4731.72(F))

The bill specifies that its prohibitions regarding billing for anatomic pathology services are not to be construed to mandate the assignment of benefits for anatomic pathology services. "Assignment of benefits" is defined as the transfer of health care coverage reimbursement benefits or other rights under an insurance policy, subscription contract, or health care plan by an insured, subscriber, or plan enrollee to a health care provider, hospital, or other health care facility.

Medical Board disciplinary actions

(R.C. 4731.72(E))

Current law authorizes the State Medical Board, by an affirmative vote of not fewer than six members, to take disciplinary action against a physician for any of a number of reasons specified in statute. The Board may limit, revoke, or suspend a physician's certificate to practice, refuse to register a physician, refuse to reinstate a physician's certificate, or reprimand or place a physician on probation.

[7] The bill specifies that the technical component of an anatomic pathology service includes only histologic processing (R.C. 4731.72(A)(3)).

The bill authorizes the State Medical Board to take disciplinary action against a physician who violates either of the bill's prohibitions regarding physician billing for anatomic pathology services. The bill specifies that a violation of either prohibition constitutes a reason for taking action under the existing law category of taking action based on any violation of the statutes or rules enforced by the Board.

HEALTH BENEFIT PLANS

Health benefits for routine patient care during cancer clinical trials

(R.C. 3923.80)

Current law prohibits a health benefit plan or public employee benefit plan from denying coverage for the costs of any routine patient care[8] administered to an insured participating in any stage of an eligible cancer clinical trial if that care would be covered under the plan if the insured was not participating in a clinical trial. An eligible cancer clinical trial is a cancer clinical trial that meets all of the following criteria:

(1) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;

(2) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;

(3) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;

(4) The trial (a) tests how to administer a health care service, item, or drug for the treatment of cancer, (b) tests responses to a health care service, item, or drug for the treatment of cancer, (c) compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer, or (d) studies new uses of a health care service, item, or drug for the treatment of cancer;

(5) The trial is approved by the National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and

[8] "Routine patient care" is defined as all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial and that was not necessitated solely because of the trial.

Human Services, the United States Food and Drug Administration, the United States Department of Defense, or the United States Department of Veterans' Affairs.

However, current law also prohibits any provision for mandated health benefits contained in a law enacted after January 14, 1993, from being applied to any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.), that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or any political subdivision of the state.[9] ERISA is a comprehensive federal statute governing the administration of employee benefit plans other than as part of "the business of insurance." ERISA pre-empts state regulation of plans operated by employers that choose to self insure rather than purchase health insurance for employees. Since the Superintendent would almost certainly find that the clinical trial provisions cannot be applied to ERISA plans because of the federal pre-emption, the apparent mandate of current law is probably unenforceable.

The bill exempts the law prohibiting a health benefit plan or public employee benefit plan from denying coverage for the costs of routine patient care administered to an insured participating in an eligible cancer clinical trial from the requirement that the Superintendent make the determination described above concerning mandated health benefits.

Health insurance coverage for alcohol or drug-caused injury

(R.C. 3923.05 and 3923.82; Section 5)

Current law requires that a policy of sickness and accident insurance delivered, issued for delivery, or used in this state that excludes coverage of loss resulting from use of intoxicants or narcotics contain a provision that reads as follows:[10]

[9] R.C. 3901.71, not in the bill. A mandated health benefit is any required coverage, or required offering of coverage, for the expenses of specified services, treatments, or diseases under any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits to policyholders, subscribers, or members.

[10] Continuing law provides that if a provision otherwise required by state law to be included in a policy of sickness and accident insurance is in whole or part inapplicable or inconsistent with the coverage provided by the policy, the insurer must, with the approval

"Intoxicants and narcotics. The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."

The bill eliminates this requirement and instead creates a new prohibition applicable to health benefit plans[11] and public employee benefit plans regarding coverage of injuries caused by alcohol or other drugs. No such plan may contain a provision that limits or excludes any insured's coverage under the plan for a loss or expense the insured sustains that is the result of the insured's use of alcohol or other drugs or both if the loss or expense is otherwise covered under the plan. The elimination of the current requirement and enactment of the new prohibition are to apply only to health benefit plans delivered, issued for delivery, or renewed in this state on or after 180 days after the bill's effective date.

The new prohibition is not subject to continuing law that prohibits any provision for mandated health benefits[12] contained in a law enacted after January 14, 1993, from being applied to any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the

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of the Superintendent of Insurance, omit from the policy or part of the policy the inapplicable provision and modify the inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy. Also, an insurer is permitted to substitute for, or use in lieu of, any of the policy provisions that state law requires be included in the policy a corresponding policy provision of different wording approved by the Superintendent that is not less favorable in any respect to the insured or the beneficiary. (R.C. 3923.07, not in the bill.)

[11] "Health benefit plan" is defined as any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; 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. (R.C. 3924.01, not in the bill.)

[12] A mandated health benefit is any required coverage, or required offering of coverage, for the expenses of specified services, treatments, or diseases under any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits to policyholders, subscribers, or members.

Administrative Procedure Act (R.C. Chapter 119.), that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or any political subdivision of the state.[13]

The new prohibition is not to be construed as (1) requiring coverage for the treatment of alcohol or substance abuse except as otherwise required by law or (2) prohibiting the enforcement of an exclusion based on injuries sustained by an insured during the commission of an offense by the insured in which the insured is convicted of or pleads guilty or no contest to a felony.

The bill requires the Department of Insurance to conduct an analysis of the new prohibition's impact on the cost of and coverage provided by health benefit plans in this state and prepare a written report of its findings. The report is to be submitted to the Governor, Senate President, Senate Minority Leader, Speaker of the House of Representatives, House Minority Leader, and Director of the Legislative Service Commission. The report is due not later than four years after the effective date of this provision of the bill.

HEALTH CARE CONTRACTS

Most favored nation clauses in health care contracts

(Sections 3 and 4)

Sub. H.B. 125 of the 127th General Assembly prohibits (1) the entering into of a health care contract[14] with a most favored nation clause and (2) a health care contract from being amended or renewed to include a most favored nation clause at the direction of a contracting entity.[15] A most favored nation clause is any provision in a health care contract that (1) prohibits, or grants a contracting

[13] R.C. 3901.71, not in the bill. ERISA governs employer plans that self-insure. These plans will not be subject to this provision of the bill.

[14] A health care contract is a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees (R.C. 3963.01(H)).

[15] A contracting entity is any person that has a primary business purpose of contracting with participating providers for the delivery of health care services (R.C. 3963.01(C)).

entity an option to prohibit, the participating provider[16] from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract, (2) requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price, (3) requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price, or (4) requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities. However, the prohibitions are not to stop the continued use of a most favored nation clause in a health care contract between a contracting entity and a hospital if the contract is in existence on June 25, 2008.[17]

Under current law, the prohibitions are in effect for a period of two years after the effective date of Sub. H.B. 125. (Sub. H.B. 125 was effective June 25, 2008.) However, Sub. H.B. 125 includes a provision under which the prohibitions may be extended. That provision concerns the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts, which Sub. H.B. 125 created. The Commission is required to issue a preliminary report regarding the issue of most favored nation clauses not less than 90 days before the expiration of the two-year period of the prohibitions. The preliminary report must include a recommendation of whether to extend the prohibitions one additional year. Sub. H.B. 125 provides that if the General Assembly grants the extension,

[16] A participating provider is a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract (R.C. 3963.01(K)). All of the following are providers: physicians, podiatrists, dentists, chiropractors, optometrists, psychologists, physician assistants, advanced practice nurses, occupational therapists, massage therapists, physical therapists, professional counselors, professional clinical counselors, hearing aid dealers, orthotists, prosthetists, home health agencies, hospice care programs, and hospitals. A provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts is also a provider. None of the following are considered to be a provider: pharmacists, pharmacies, and nursing homes. A provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds is not considered to be a provider either. (R.C. 3963.01(P).)

[17] This is so even if the health care contract is materially amended with respect to any provision of the contract other than the most favored nation clause during the period the prohibitions are in effect.

the extension is not to be for more than one year after the expiration of the initial two-year period.[18]

The bill extends the period that the prohibitions are to be in effect except as regards health care contracts with hospitals. With the exception of hospitals, the prohibitions are to be in effect for a period of three years, rather than two, after June 25, 2008. And the reference to the possible one-year extension of the prohibitions following the report of the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts is removed except regarding health care contracts with hospitals. The bill does not change the period for which the prohibitions are to be in effect for health care contracts with hospitals. Nor does the bill remove the reference to the possible one-year extension as regards health care contracts with hospitals.

HISTORY

ACTION	DATE
Introduced	03-05-08
Reported, H. Health	05-22-08
Passed House (92-3)	05-29-08
Reported, S. Health, Human Services, & Aging	12-11-08

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[18] Even though current law provides that the extension could not be for more than one year, the General Assembly could provide for the extension to be longer because the General Assembly has the constitutional authority to make the law.