Bill Analysis

Jeffery A. Bernard *Legislative Service Commission*

Sub. S.B. 278*

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

Sens. Coughlin, Stivers, Mumper, Spada, D. Miller, Morano, Kearney

BILL SUMMARY

- Requires that benefits for colorectal examinations and laboratory tests for cancer be included in certain health care policies, contracts, and agreements; public employee benefit plans; and the state's Medicaid program.

CONTENT AND OPERATION

Benefits for colorectal examinations and laboratory tests for cancer

(R.C. 1751.69, 3923.651, and 5111.017)

The bill requires certain health care policies, contracts, and agreements; public employee benefit plans; and the state's Medicaid plan to provide health care benefits for colorectal examinations and laboratory tests for cancer. These benefits must be provided to any non-symptomatic individual who is either of the following:

(1) Fifty years of age or older;

(2) Less than 50 years of age and at high risk for colorectal cancer due to one of the following:

(a) A personal history of colorectal cancer or adenomatous polyps;

(b) A personal history of chronic inflammatory bowel disease, such as Crohns disease or ulcerative colitis;

* This analysis was prepared before the report of the Senate Health, Human Services, and Aging Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

(c) A family history of colorectal cancer or polyps, determined by cancer or polyps in a first degree relative younger than 60 or more than two first degree relatives of any age;

(d) A known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis or hereditary nonpolyposis colon cancer.

The benefits are to include all of the following:

(1) Flexible sigmoidoscopy every five years;

(2) Colonoscopy every ten years;

(3) Double contrast barium enema every five years;

(4) CT colonography every five years;

(5) A stool DNA test with high sensitivity for cancer every five years or one of the following annual tests:

(a) Guaiac-based fecal occult blood test with high test sensitivity for cancer;

(b) Fecal immunochemical test with high test sensitivity for cancer;

(c) Any combination of the most reliable, medically recognized screening tests available.

Plans required to provide benefits

(R.C. 1751.69, 3923.651, and 5111.017)

The benefits required by the bill are to be provided by (1) individual or group health insuring corporation policies, contracts, or agreements providing basic health care services, (2) policies of individual or group sickness and accident insurance, (3) public employee benefit plans, and (4) the state Medicaid plan.

The bill expressly provides that all terms, conditions, restrictions, exclusions, and limitations that apply to any other coverage under the policy, contract, plan, or agreement for services performed by participating and nonparticipating providers are to apply to the benefits required under the bill. It specifies that nothing in it may be construed as requiring reimbursement to a provider or facility providing the examination or test that does not have a health care contract with the insurer or prohibiting an insurer that does not have a health care contract with such a provider or facility from negotiating a single case or other agreement for coverage.

Exemptions

(R.C. 3923.651(C))

The bill does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, Medicare supplement, or other policy that offers only supplemental benefits.

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)[1] and (2) employee benefit plans established or modified by the state or its political subdivisions. (Section 3901.71, not in the bill.) The bill exempts 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 that the Director 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	01-23-08
Reported, S. Health, Human Services & Aging	---

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