Ohio Legislative Service Commission

Bill Analysis

Katie Bentley

H.B. 56

128th General Assembly
(As Introduced)

Reps. Miller, S. Williams, Pillich, Ujvagi, Fende, Okey, Yuko, Boyd, Chandler, Dyer, Koziura, Hall, Winburn, DeBose, Letson

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.

CONTENT AND OPERATION

Benefits for colorectal examinations and laboratory tests for cancer

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

The bill requires health care policies, contracts, agreements, and plans of health insuring corporations, sickness and accident insurers, multiple welfare arrangements, and public employee benefit plans to provide health care benefits for colorectal examinations and laboratory tests. These benefits must be provided to any symptomatic or 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 according to the American Cancer Society's most recent cancer screening guidelines.

The bill also requires the state's Medicaid plan to provide benefits for colorectal examinations and laboratory tests for cancer. However, under the bill, the state's Medicaid program is only required to provide those benefits for the above *non-symptomatic* individuals.

The benefits provided under the bill must be for examinations and laboratory tests performed in accordance with the most recently published cancer screening guidelines of the American Cancer Society. The benefits are subject to the same terms and conditions, including copayment charges, that apply to similar benefits provided under a policy, contract, or agreement, or a public employee benefit plan.

Exemption for supplemental policies

(R.C. 1751.69(A) and 3923.651(D))

The bill does not apply to health insuring corporation policies, contracts, or agreements that do not cover basic health care services[1] (i.e. supplemental policies) or 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 of review by the Superintendent of Insurance

(R.C. 1751.69(A) and 3923.651(A))

The coverage required under this bill may be considered mandated health benefits. Under section 3901.71 of the Revised Code, no mandated health benefits[2] legislation enacted by the General Assembly may be 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 federal Employee Retirement Income Security Act of 1974

[1] Under section 1751.01 of the Revised Code, "basic health care services" means the following services when medically necessary: (1) physician's services, except when such services are supplemental, (2) inpatient hospital services, (3) outpatient medical services, (4) emergency health services, (5) urgent care services, (6) diagnostic laboratory services and diagnostic and therapeutic radiologic services, (7) diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses, (8) preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well child care, (9) routine patient care for patients enrolled in an eligible cancer clinical trial.

[2] Section 3901.71 of the Revised Code defines "mandated health benefits" as 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.

(ERISA)[3] and (2) employee benefit plans established or modified by the state or any political subdivision of the state, or by any agency or instrumentality of the state or any political subdivision of the state. The bill includes a provision that exempts its requirements from this restriction.

HISTORY

ACTION	DATE
Introduced	03-03-09

h0056-i-128.docx/kl

[3] ERISA is a comprehensive federal statute that governs the administration of employee benefit plans. ERISA generally precludes direct state regulation of benefits offered by private employers but allows state regulation of the business of insurance. Therefore, ERISA preempts the state's ability to require private self-insuring employers to offer to cover certain services.