Ohio Legislative Service Commission

Bill Analysis

Katie Bentley

H.B. 134

128th General Assembly
(As Introduced)

Reps. DeBose, Fende, B. Williams, Newcomb, Domenick, Heard, Luckie, Chandler, Skindell, Brown

BILL SUMMARY

- Requires certain health care insurers and plans, including the state's Medicaid program, to offer to provide benefits for prostate, colorectal, ovarian, and cervical cancer screening examinations and laboratory tests.

CONTENT AND OPERATION

Current law

Current law requires health insuring corporations, sickness and accident insurers, public employee benefit plans, employers that provide sickness and accident insurance for their employees, and Ohio's Medicaid program to provide benefits for the expenses of cytologic screening for the presence of cervical cancer if the screening is processed and interpreted in a laboratory certified by the College of American Pathologists or in a "hospital" as defined in Ohio's Hospital Certification and Accreditation Law (R.C. 3727.01) (R.C. 1751.62, 3923.52, 3923.53, 3923.54, and 5111.024, not in the bill).

Coverage for certain cancer screening examinations and tests

The bill requires health insuring corporations, sickness and accident insurers, public employee benefit plans, and the state's Medicaid program to offer to provide benefits for prostate, colorectal, ovarian, and cervical cancer screening examinations and laboratory tests (R.C. 1751.69, 3923.90, and 5111.026). Under the bill, a health insuring corporation must offer those benefits as supplemental health care service benefits (R.C. 1751.69).

Scope of coverage

If, under the bill, a health insuring corporation, sickness and accident insurer, public employee benefit plan, or the state's Medicaid program provides the above coverage, that coverage must be provided to any nonsymptomatic individual for whom the most recently published American Cancer Society guidelines recommend screening based on age, health, and other risk factors. (R.C. 1751.69, 3923.90, and 5111.026.)

The bill only requires coverage for the examinations and laboratory tests recommended by, and performed in accordance with, the most recently published American Cancer Society guidelines. Additionally, that coverage may be subject to the same terms and conditions that apply to similar benefits under the policy, contract, or agreement including copayment charges. (R.C. 1751.69, 3923.90, and 5111.026.)

The bill specifies that its requirements do not apply to sickness and accident insurance policies that provide coverage for specific diseases or accidents only, or to any hospital indemnity, Medicare supplement, or other policy that offers supplemental benefits. Additionally, the bill's requirements would only apply to policies, plans, contracts, and agreements delivered, issued for delivery, renewed, or modified after the effective date of the bill (Section 2).

Exemption from review by the Superintendent of Insurance

The coverage required under this bill may be considered mandated health benefits. Under section 3901.71 of the Revised Code, no mandated health benefits[1] 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 (ERISA)[2] 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

[1] 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.

[2] 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.

political subdivision of the state. The bill includes a provision that exempts its requirements from this restriction. (R.C. 1751.69 and 3923.90.)

HISTORY

ACTION	DATE
Introduced	04-16-09

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