Ohio Legislative Service Commission

Bill Analysis

Laura Gengo

H.B. 287

128th General Assembly
(As Introduced)

Reps. Burke and Sears, J. Adams, Baker, Balderson, Blair, Boose, Goodwin, Grossman, Lehner, Morgan, Snitchler, Wachtmann

BILL SUMMARY

- Prohibits a mandated health benefit from being applied to a policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Medicaid program covers the health benefit.
- Requires the Medicaid program to cover a mandated health benefit unless the U.S. Secretary of Health and Human Services refuses to approve federal financial participation for the health benefit.

CONTENT AND OPERATION

Restriction on mandated health benefits

(R.C. 3901.71)

Current law establishes a restriction on the application of statutes that establish mandated health benefits.[1] Under this restriction, no statutory provision for mandated

[1] A mandated health benefit is defined 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 (R.C. 3901.71(A)).

Examples of existing mandated health benefits include (1) diagnostic and treatment services for biologically based mental illnesses (R.C. 1751.01(A)(1)(g)), 3923.28 to 3923.30, and 3923.30), (2) screening mammography for breast cancer and cytological screening for cervical cancer (R.C. 1751.62, 3923.52, and 3923.53), (3) minimum lengths of inpatient care following childbirth (48 hours for normal delivery; 96 hours for Cesarean delivery) (R.C. 1751.67, 3923.63, and 3923.64), and (4) "off-label" drug use, which is when a drug is prescribed for an indication that is not specified in the drug's federally required labeling,

health benefits enacted after January 14, 1993,[2] may be applied to a policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans regulated under the federal Employee Retirement Income Security Act (ERISA)[3] and to employee benefit plans established or modified by the state or any political subdivision of the state.[4]

The bill adds a restriction on new mandated health benefits that is based on whether there is equivalent Medicaid coverage of the health benefit. Specifically, the bill provides that a statute establishing a mandated health benefit enacted after the bill's effective date is not to be applied to a policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Medicaid program covers the health benefit.

Medicaid coverage of mandated health benefits

(R.C. 5111.0210)

The bill requires the Medicaid program to cover all health benefits that Ohio, by statute, requires a policy, contract, plan, or other arrangement providing sickness and accident or other health benefits to cover or offer to cover. However, this requirement for Medicaid coverage is not to be applied to a health benefit if the U.S. Secretary of Health and Human Services refuses to approve a Medicaid state plan amendment or federal Medicaid waiver that is necessary for Ohio to obtain federal financial participation for the health benefit. The bill requires the Director of Job and Family Services to seek approval for such Medicaid state plan amendments and federal Medicaid waivers.

---

but medical literature has recognized the drug as being a safe and effective treatment for that indication (R.C. 1751.66, 3923.60, and 3923.61).

[2] January 14, 1993, is the effective date of Am. Sub. H.B. 478 of the 119th General Assembly. H.B. 478 contained comprehensive provisions pertaining to health benefits and health insurers.

[3] ERISA preempts state regulation of certain types of employee benefit plans and has been interpreted as being applicable to health benefits offered by employers that "self-insure." When an employer self-insures, the employer assumes the risk of the costs associated with providing the health benefits, as opposed to purchasing insurance coverage from a third-party that assumes the risk of those costs.

[4] The bill modifies this law by providing that a statutory provision for mandated health benefits is not to be so applied to "any policy, contract, plan, or other health benefits," rather than "any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits." The purpose of the change is not apparent, and a corrective amendment may be necessary to restore the provision to its original form.

HISTORY

ACTION	DATE
Introduced	09-29-09

h0287-i-draft-128.docx/kl