Ohio Legislative Service Commission

Bill Analysis

Ashley Blackburn

H.B. 376

129th General Assembly
(As Introduced)

Reps. Celeste and Garland, Antonio, Ashford, Barnes, Boyd, Carney, Clyde, DeGeeter, Driehaus, Fedor, Fende, Foley, Gentile, Gerberry, Goyal, R. Hagan, Heard, Letson, Lundy, Mallory, Milkovich, Murray, O'Brien, Okey, Patmon, Phillips, Pillich, Ramos, Reece, Slesnick, Stinziano, Sykes, Szollosi, Weddington, Winburn, Yuko

BILL SUMMARY

- Prohibits health insurers from excluding coverage for specified autism services for individuals diagnosed with an autism spectrum disorder.
- Requires the Director of Developmental Disabilities to convene a committee on the coverage of autism spectrum disorders to investigate and recommend additional treatments or therapies for autism spectrum disorders to be covered by health insurers and the qualifications of the providers of those treatments or therapies.

CONTENT AND OPERATION

Coverage for autism services

The bill prohibits policies, contracts, agreements, and plans of health insuring corporations, sickness and accident insurers, public employee benefit plans, and multiple employer welfare arrangements from excluding coverage for the screening and diagnosis of autism spectrum disorders or for any of the following services for individuals already diagnosed with an autism spectrum disorder: habilitative or rehabilitative care, psychiatric care, psychological care, therapeutic care, and counseling services. Additionally, at the recommendation of the Committee on the Coverage of Autism Spectrum Disorders (see "**The Committee on the Coverage Autism Spectrum Disorders**" below), the Director of Developmental Disabilities may adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) to include other treatments or therapies for autism spectrum disorders that policies, contracts, agreements, and plans would be required to cover. The bill also prohibits those policies, contracts, agreements, and plans from excluding coverage for pharmacy care if

the policy, contract, or agreement provides coverage for other prescription drug services.

The above services, however, must be medically necessary and prescribed, provided, or ordered by a health care professional licensed or certified in Ohio to prescribe, provide, or order those services.[1]

Additionally, the required coverage must be delineated in a treatment plan developed by the attending psychologist or physician and cannot be subject to limits on the number or duration of visits that an individual makes to an autism service provider, except as delineated in the treatment plan, if the services are medically necessary.[2] The bill's requirements may, however, be subject to any copayment, deductible, and coinsurance provisions of the policy, contract, agreement, or plan to the extent that other medical services covered by the policy, contract, agreement, or plan are subject to those requirements. The coverage required under the bill also can be subject to a yearly maximum limitation of $36,000 on claims paid for services related to the required coverage.[3]

Under the bill, a provider must provide the insurer with an annual treatment plan if requested by the insurer.[4] An insurer also may request a review of any treatment provided under the bill's requirements but not more than once every six months unless the insured's licensed physician or licensed psychologist agrees that more frequent review is necessary. The insurer must pay for any such review it requests. Inpatient services are not subject to this six-month review limitation.[5]

The bill specifies that its coverage requirements may not be construed as limiting benefits otherwise available under an individual's policy, contract, agreement, or plan.[6] With regard to health insuring corporations, the services covered under the bill cannot be considered supplemental health care services.[7] The effect of this provision seems to be that health insuring corporation contracts covering employees would have to, at the employee's option, continue providing the coverage required under the bill to that

---

[1] R.C. 1739.05, 1751.68(A), and 3926.84(A).

[2] R.C. 1751.68(B) and 3923.84(B).

[3] R.C. 1751.68(C) and 3923.84(C).

[4] R.C. 1751.68(D)(2) and 3923.84(D)(2).

[5] R.C. 1751.68(D)(1) and (3) and 3923.84(D)(1) and (3).

[6] R.C. 1751.68(E) and 3923.84(E).

[7] R.C. 1751.68(H).

employee for six months after that employee's loss of employment. Under R.C. 1751.53(B), not in the bill, a health insuring corporation contract covering employees has to provide that any eligible employee may continue the coverage under the contract, for the employee and the employee's eligible dependents, for a period of six months after the date that the group coverage would otherwise terminate by reason of the termination of the employee's employment. This continuation need not include any supplemental health care services benefits or specialty health care services benefits provided by the group contract. "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes a variety of specified services and any category of services approved by the Superintendent of Insurance.[8]

Exception for supplemental policies

The bill's requirement for coverage of autism services does not apply to health insuring corporation policies, contracts, or agreements that do not cover basic health care services (i.e. supplemental policies) or to any policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, medicare, tricare, long-term care, disability income, one-time limited duration policy of not longer than six months, or other policy that offers only supplemental benefits.[9]

Under the Health Insuring Corporation Law, "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, and (9) routine patient care for patients enrolled in an eligible cancer clinical trial.[10]

Opt out provision

Under the bill, an insurer is not required to provide the coverage required by the bill if all of the following conditions are met:

---

[8] R.C. 1751.01(B) and 1751.53.

[9] R.C. 1751.68(A) and 3923.84(G).

[10] R.C. 1751.01.

(1) The insurer submits documentation certified by an independent member of the American Academy of Actuaries to the Superintendent of Insurance showing that incurred claims for the coverage required under the bill for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all covered services to increase by more than 1% per year.

(2) The insurer submits a signed letter from an independent member of the American Academy of Actuaries to the Superintendent of Insurance opining that the increase in costs could reasonably justify an increase of more than 1% in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services or by the insurer for the coverage of all covered services.

(3) The Superintendent of Insurance determines, from the documentation and opinion submitted, that the incurred claims for the coverage required under the bill for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all covered services to increase by more than 1% per year, that the increase in costs reasonably justifies an increase of more than 1% in the annual premiums or rates charged by the insurer for the coverage of basic health care services (health insuring corporations) or all covered services (sickness and accident insurers, public employee benefit plans, and multiple employer welfare arrangements).

Any such determination made by the Superintendent of Insurance is subject to the Administrative Procedure Act.[11]

Effect on existing programs

The bill specifies that its requirements should not be construed as affecting any obligation to provide services to an individual under either an Individualized Family Service Plan developed under federal law including Ohio's Help Me Grow program,[12] or an individualized service plan established by a county Board of Developmental Disabilities for adults for the prevention, correction, or discontinuance of abuse or neglect or of a condition resulting from abuse or neglect for any adult who has been determined to need the services and consents to receive them.[13] The bill also should not be construed as affecting the duty of a public school to provide a child with a disability

[11] R.C. 1751.39, 1751.68(G), and 3923.84(H).

[12] 20 U.S.C. 1436 and R.C. 3701.61.

[13] R.C. 5126.31, not in the bill.

with a free appropriate public education under Ohio law[14] and the federal Individuals with Disabilities Education Improvement Act of 2004.[15]

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 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, 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) 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.[16]

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 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.

The Committee on the Coverage of Autism Spectrum Disorders

The bill requires the Director of Developmental Disabilities to convene a committee on the coverage of autism spectrum disorders that serves at the pleasure of the Director of Developmental Disabilities. The committee must investigate and recommend to the Director of Developmental Disabilities treatments or therapies for autism spectrum disorders that the committee believes should be included in the services that health insuring corporations, sickness and accident insurers, public

[14] R.C. Chapter 3323.

[15] R.C. 1751.68(F) and 3923.84(F).

[16] R.C. 1751.68(A) and 3923.84(A).

employee benefit plans, and multiple employer welfare arrangements are required to cover under the bill and the qualifications of the providers of those treatments and therapies.

Under the bill, the committee must consist of nine members appointed by the Director of Developmental Disabilities. Those members must include the Director of Developmental Disabilities, the Director of Health, at least one licensed physician, licensed psychologist, and parent of an individual diagnosed with an autism spectrum disorder.[17]

Definitions

The bill defines the following terms:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) "Autism services provider" means any person whose professional scope of practice allows treatment of autism spectrum disorders, whose services are delineated in the treatment plan developed by the attending psychologist or physician, and who is either licensed, certified, or registered by an appropriate Ohio agency to perform the services assigned to the person in the treatment plan or directly supervised by such an individual.

(3) "Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or if that manual is no longer published, a similar diagnostic manual. Autism spectrum disorder includes autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests, including genetic and psychological tests to determine whether an individual has an autism spectrum disorder.

(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that

[17] R.C. 3923.84(I).

are necessary to develop, maintain, or restore the functioning of an individual to the maximum extent practicable.

(6) "Medically necessary" means the service is based upon evidence; is prescribed, provided, or ordered by a health care professional licensed or certified under Ohio law to prescribe, provide, or order autism-related services in accordance with accepted standards of practice; and will or is reasonably expected to do any of the following:

(a) Prevent the onset of an illness, condition, injury, or disability;

(b) Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability;

(c) Assist in achieving or maintaining maximum functional capacity for performing daily activities, taking into account both the functional capacity of the individual and the appropriate functional capacities of individuals of the same age.

(7) "Pharmacy care" means prescribed medications and any medically necessary health-related services used to determine the need or effectiveness of the medications.

(8) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in Ohio in which the psychiatrist practices psychiatry.

(9) "Psychological care" means direct or consultative services provided by a psychologist licensed in Ohio in which the psychologist practices psychology.

(10) "Therapeutic care" means services, communication devices, or other adaptive devices or equipment provided by a licensed speech-language pathologist, licensed occupational therapist, or licensed physical therapist.[18]

HISTORY

ACTION	DATE
Introduced	11-15-11

h0376-i-129.docx/ks

[18] R.C. 1751.68(I) and 3923.84(J).