Ohio Legislative Service Commission

Bill Analysis Elizabeth Molnar

H.B. 361

130th General Assembly
(As Introduced)

Reps. Gonzales and Smith, Landis

BILL SUMMARY

- Prohibits health insurance provided by certain insurers from excluding coverage for services related to acquired brain injuries, except when insurer costs exceed specified limits.

CONTENT AND OPERATION

Insurance coverage for acquired brain injuries

Except when costs incurred by an insurer exceed limits specified in the bill, the bill prohibits a health insurance policy, contract, agreement, or plan that provides basic health services from excluding coverage for certain services related to an acquired brain injury (a brain injury caused by events occurring after birth).[1] The insurers subject to the bill are health insuring corporations, public employee benefit plans, sickness and accident insurers, and multiple employer welfare arrangements.[2] The bill applies to policies, contracts, agreements, or plans issued, delivered, renewed, established, or modified in Ohio after the bill's effective date.[3] It does not apply to health insurance that is part of employee benefits offered by private employers that self-insure their benefit programs. These programs are generally precluded from state regulation by the federal Employee Retirement Income Security Act (ERISA) (see "**ERISA**," below).

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[1] R.C. 1751.68(A)(2).

[2] R.C. 1739.05, 1751.68, and 3923.591.

[3] Section 3 of the bill.

Covered services

The bill provides that the following services, if they are considered medically necessary by a treating physician and result from or are related to an acquired brain injury, cannot be excluded from insurance coverage under a health insurance policy, contract, agreement, or plan:

(1) Cognitive rehabilitation therapy;

(2) Cognitive communication therapy;

(3) Neurocognitive therapy and rehabilitation;

(4) Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;

(5) Neurofeedback therapy;

(6) Remediation;

(7) Community reintegration services;

(8) Post-acute rehabilitation care treatment.[4]

The bill does not prohibit the covered services from being subject to deductibles, copayments, and coinsurance.[5]

Post-acute rehabilitation care treatment

"To ensure that appropriate post-acute rehabilitation care treatment is provided," health insurance subject to the bill must include coverage for reasonable expenses related to the periodic reevaluation of care for an enrollee who has an acquired brain injury, has been unresponsive to treatment, and later becomes responsive to treatment.

When determining whether expenses are reasonable, the insurer may consider any factor, including cost, time between evaluations, physician or practitioner expertise, technological changes, and medical advances.[6]

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[4] R.C. 1739.05(B), 1751.68(A), and 3923.591(B).

[5] R.C. 1739.05(B), 1751.68(F), and 3923.591(C).

[6] R.C. 1739.05(B), 1751.68(C), and 3923.591(C).

Treatment facilities

The bill specifies that an insurer cannot deny coverage for a service related to an acquired brain injury solely because it is provided at a facility other than a hospital. Under the bill, services may be provided at any appropriate facility, including (1) a hospital, including an acute or post-acute rehabilitation hospital, (2) a residential care facility, and (3) a freestanding inpatient rehabilitation facility.[7] Residential care facilities and freestanding inpatient rehabilitation facilities are licensed by the Ohio Department of Health.

Residential care and freestanding inpatient rehabilitation facilities

The bill contains several provisions concerning services provided at residential care or freestanding inpatient rehabilitation facilities. It prohibits an insurer from refusing to contract with or approve admission to a facility solely because it is a residential care or freestanding inpatient rehabilitation facility.[8]

The bill requires that an insurer who requires or encourages enrollees to use designated health care providers ensure that services related to an acquired brain injury and within the scope of a facility's license are made available and accessible to enrollees at an adequate number of facilities.[9]

The bill prohibits an insurer from treating services related to an acquired brain injury and provided by a residential care facility as custodial care if the facility has a rehabilitation program for acquired brain injury accredited by the Commission on Accreditation of Rehabilitation Facilities or another nationally recognized accreditation organization.[10]

"To ensure the health and safety of enrollees," the Superintendent may require that a facility providing post-acute rehabilitation treatment have a rehabilitation program for acquired brain injury that is accredited by the Commission on Accreditation of Rehabilitation Facilities or another nationally recognized accreditation organization.[11]

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[7] R.C. 1739.05(B), 1751.68(D)(1), and 3923.591(D)(1).

[8] R.C. 1739.05(B), 1751.68(D)(2), and 3923.591(D)(2).

[9] R.C. 1739.05(B), 1751.68(D)(3), and 3923.591(D)(3).

[10] R.C. 1739.05(B), 1751.68(D)(4), and 3923.591(D)(4).

[11] R.C. 1739.05(B), 1751.68(D)(5), and 3923.591(D)(5).

Coverage exception

In the event that certain costs incurred by an insurer exceed 1% per year, benefits for services related to an acquired brain injury need not be provided. Such coverage can be excluded if all of the following apply:

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

(2) The insurer submits to the Superintendent a signed letter from an independent member of the American Academy of Actuaries opining that the increase from incurred claims for covered services could reasonably justify an increase of more than 1% in the annual premiums or rates charged by the insurer for coverage of all other physical diseases and disorders;

(3) The Superintendent makes both of the following determinations from the documentation and letter submitted by the insurer:

(a) Incurred claims for services related to acquired brain injuries for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for coverage of all other physical diseases and disorders to increase by more than 1% per year;

(b) The increase in costs reasonably justifies an increase of more than 1% in the annual premiums or rates charged by the insurer for coverage of all other physical diseases and disorders.[12]

Superintendent of Insurance

The bill contains additional provisions concerning the Superintendent of Insurance.

Rulemaking authority

The bill directs the Superintendent to adopt rules requiring health insuring corporations, sickness and accident insurers, multiple employer welfare arrangements, and public employee benefit plans to provide adequate training to injurer personnel

[12] R.C. 1739.05(B), 1751.68(E), and 3923.591(E).

responsible for preauthorization of coverage or utilization reviews in order to do the following:

(1) Prevent wrongful denial of coverage for services related to acquired brain injuries;

(2) Avoid confusion of medical benefits with mental health benefits.

The bill also directs the Superintendent to consult with the Brain Injury Advisory Committee before adopting these rules.[13] The Committee was created by the General Assembly to advise the Brain Injury Program at the Ohio State University.[14]

Review of mandated benefits legislation

The bill exempts from review by the Superintendent its requirements concerning coverage of services related to an acquired brain injury.[15] Under current law, legislation mandating health benefits cannot apply to any health benefits arrangement until the Superintendent holds a public hearing and determines that it can be applied fully and equally in all respects to employee benefits plans that are subject to ERISA or established or modified by the state or its political subdivisions.[16] Under the bill, this hearing and determination are not required.

ERISA

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 sickness and accident insurer or health insuring corporation.

HISTORY

ACTION	DATE
Introduced	11-26-13

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[13] R.C. 3901.046 and 3335.61, not in the bill.

[14] R.C. 3335.61, not in the bill.

[15] R.C. 1739.05(B), 1751.68(B), and 3923.591(B).

[16] R.C. 3901.71.