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ACT SUMMARY

- Provides for the review of health care coverage decisions made by a health insuring corporation by establishing requirements for conducting reviews within the corporation (internal reviews) and apart from the corporation through independent review organizations or the Superintendent of Insurance (external reviews).
- Allows a woman who receives benefits through a health insuring corporation to obtain services from an obstetrician or gynecologist without a referral from her primary care physician.
- Requires a health insuring corporation to provide enrollees with at least one toll-free telephone number for health plan information, including information on the plan's internal and external review processes.
- Requires that sickness and accident insurers and public employee benefit plans implement external review processes in the same manner as health insuring corporations.

- Requires sickness and accident insurers to cover emergency medical services without regard to when the services were rendered or whether prior authorization was obtained.
- Permits deductions from the Ohio income tax for certain medical expenses and long-term care insurance.

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CONTENT AND OPERATION

COVERAGE DECISIONS BY HEALTH INSURING CORPORATIONS

Overview

The act expands and otherwise modifies laws that pertain to the health care coverage decisions made by a health insuring corporation through its "utilization review" process. Under the act, a health insuring corporation that engages in utilization review must establish an internal review system. If there is disagreement with the determination made in an internal review, the act provides for additional review through one of two external review systems. If the issue involves the terms of coverage under a health insuring corporation's contract, the additional review is to be conducted by the Superintendent of Insurance. If the issue requires resolution of a medical issue, the review is to be conducted by an independent review organization. In this case, the external review system is similar to the system that was established prior to the act for the external review of coverage decisions involving persons with terminal conditions.

Utilization review

(sec. 1751.81(H)(2))

Under continuing law, "utilization review" is a process used by a health insuring corporation to monitor the use of, or evaluate the clinical necessity,



appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. A health insuring corporation is required to have written procedures to address the failure or inability of a health care facility, provider (a physician or other health professional), or enrollee (the person who receives health benefits through the corporation) to provide all necessary information for utilization review. The act prohibits a health insuring corporation from using unreasonable requests for information to delay making a determination.

Reconsideration

(sec. 1751.82)

Under continuing law, when a health insuring corporation's utilization review results in a determination to deny, reduce, or terminate payment for a health service, the provider or health care facility rendering health care has the opportunity to request a reconsideration of the determination on behalf of the enrollee. The act stipulates that the request may not be made without the enrollee's consent.

Internal review of contractual terms

(sec. 1751.81(B))

Under the act, a health insuring corporation that engages in utilization review must maintain written procedures for determining whether a requested service is a service covered under the terms of an enrollee's policy, contract, or agreement. The corporation also must maintain written procedures for providing notice of its determinations.

Internal review of medical issues

(sec. 1751.83)

The act requires a health insuring corporation that engages in utilization review to establish and maintain an internal review system that has been approved by the Superintendent of Insurance. Under its internal review system, the health insuring corporation reviews adverse determinations that occur through utilization review. An "adverse determination" continues to be defined as a decision by a health insuring corporation or its designee utilization review organization to deny, reduce, or terminate coverage of a health service. The act, however, modifies the meaning to account for decisions under which coverage is denied because a service is not included in the terms of an enrollee's policy, contract, or agreement with a health insuring corporation.

Procedures

Each internal review system must include adequate and reasonable procedures for review and resolution of appeals from enrollees. The procedures must include procedures for verifying and reviewing appeals from enrollees whose medical conditions require expedited review.

Clinical peers

Each internal review system must provide for review by a clinical peer. A "clinical peer" continues to be defined as a physician or other licensed health professional who reviews the clinical appropriateness of a health service. In the case of a physician, however, the act provides that the physician may be licensed in a state other than Ohio.

Time frames

The act requires a health insuring corporation to consider and provide a written response to each request for an internal review not later than 60 days after receipt of the request. If the seriousness of the enrollee's medical condition requires an expedited review, however, the health insuring corporation must provide the written response not later than seven days after receipt of the request.

Response

The internal review response must state the reason for the health insuring corporation's decision, inform the enrollee of the right to pursue further review, and explain the procedures for initiating the review, including the time frames for requesting the review. If the health insuring corporation has denied, reduced, or terminated coverage for a health service on the grounds that the service is not a service covered under the terms of the enrollee's policy, contract, or agreement, the response must inform the enrollee of the right to request a review by the Superintendent of Insurance. If the service was denied, reduced, or terminated on the grounds that the service is not medically necessary, the response must inform the enrollee of the right to request an external review by an independent review organization.

Records

The health insuring corporation is required by the act to make available, for the Superintendent's inspection, copies of all documents related to internal reviews, including medical records, and copies of responses. The documents must be made available for three years following completion of the review.

Complaint system

(sec. 1751.19)

Continuing law requires a health insuring corporation to establish and maintain a complaint system to provide adequate and reasonable procedures for the resolution of written complaints by enrollees concerning any matter related to services provided by the corporation. Under the act, a health insuring corporation may establish a single system for receiving and reviewing complaints and requests for internal reviews, as long as the system meets the requirements applicable under continuing law for a complaint system and under the act for an internal review system.

External review of contractual terms

(sec. 1751.831)

The Superintendent of Insurance is required by the act to establish and maintain a system for receiving and reviewing requests for review from or on behalf of enrollees who have been denied coverage of a health service or had coverage reduced or terminated when the grounds for the denial, reduction, or termination is that the service is not covered under the terms of the enrollee's policy, contract, or agreement.

On receipt of a written request from an enrollee or a person authorized to act on the enrollee's behalf, the Superintendent must consider whether the health service is covered under the terms of the enrollee's policy, contract, or agreement. The Superintendent cannot conduct a review, however, unless the enrollee has exhausted the health insuring corporation's internal review process. The health insuring corporation and the enrollee or person acting on the enrollee's behalf must provide any information required by the Superintendent that is in their possession and is germane to the review.

Unless the determination requires resolution of a medical issue, the act requires that the Superintendent determine whether the health service at issue is a covered service. The Superintendent must notify the enrollee and the health insuring corporation of the coverage determination or that the Superintendent is not able to make a determination because it involves a medical issue.

If the Superintendent notifies the health insuring corporation that making the determination requires the resolution of a medical issue, the health insuring corporation must afford the enrollee an opportunity for an external review. If the health insuring corporation is notified that the health service is covered, it must either cover the service or afford the enrollee an opportunity for external review.

If the health insuring corporation is notified that the service is not covered, the corporation is not required to cover the service or afford the enrollee an external review.

External review of medical issues

(sec. 1751.84)

In addition to the external review procedures established under continuing law for enrollees with terminal conditions, the act requires each health insuring corporation that engages in utilization review to establish external review procedures for the appeal of a decision that a health service sought by an enrollee is not medically necessary.

Eligibility

The act provides that a health insuring corporation must afford an enrollee an opportunity for an external review if both of the following are the case:

(1) The corporation has denied, reduced, or terminated coverage for what would be a covered service except for the fact that the health insuring corporation has determined that the service is not medically necessary;

(2) Except in the case of an expedited review, the proposed service, plus any ancillary services and follow-up care, will cost the enrollee more than \$500 if the proposed service is not covered by the health insuring corporation.

Under the act, an enrollee need not be afforded an external review if any of the following circumstances exist: (1) the Superintendent of Insurance has determined that the service is not covered under the terms of the enrollee's policy, contract, or agreement, (2) the enrollee has failed to exhaust the health insuring corporation's internal review process, (3) the enrollee has previously been afforded an external review for the same adverse determination and no new clinical information has been submitted to the health insuring corporation, or (4) the enrollee requests an external review later than 60 days after receiving notice of the result of an internal review.

Requests

The act provides that an external review may be requested by the enrollee, a person authorized to act on behalf of the enrollee, the enrollee's provider, or a health care facility serving the enrollee. The act specifies that the enrollee may request a review without the approval of the provider or the health care facility;

the provider or facility, however, may not request a review without the enrollee's consent.

An external review must be requested in writing, except that if the enrollee has a condition that requires expedited review, the review may be requested orally or by electronic means. When an oral or electronic request is made, written confirmation of the request must be submitted to the health insuring corporation not later than five days after the request is submitted.

Except in the case of an expedited review, a request for an external review must be accompanied by written certification from the enrollee's provider or health care facility that the proposed service, plus any ancillary services and follow-up care, will cost the enrollee more than \$500 if the service is not covered by the health insuring corporation. For an expedited review, the enrollee's provider must certify that the enrollee's condition could, in the absence of immediate medical attention, result in any of the following: (1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the enrollee or the unborn child, in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Reviewer expertise

(sec. 3901.81)

The act provides for the external review to be conducted by an independent review organization that has been accredited by the Superintendent of Insurance and selected by the health insuring corporation from one of two organizations that the Superintendent randomly assigns to the case. The independent review organization selected to conduct the review is required by the act to utilize the services of clinical peers who have expertise in the treatment of the medical condition of the enrollee and clinical experience in the past three years with the service that has been requested or recommended. The review must be conducted by a single clinical peer, unless the health insuring corporation determines that more than one clinical peer is needed. The clinical peer must hold a license to practice that is not restricted in any manner and cannot have been disciplined or sanctioned by a hospital or government entity based on the quality of care provided by the peer. In the case of a physician, the clinical peer must be certified by a nationally recognized medical specialty board in the area that is the subject of the review.

Decision making

(sec. 1751.84)

In making its decision, the independent review organization conducting the review is required by the act to take into account all of the following:

(1) Information submitted by the health insuring corporation, the enrollee, the enrollee's provider, and the health care facility rendering the health care service, including the enrollee's medical records and the standards, criteria, and clinical rationale used by the health insuring corporation to make its decision;

(2) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, the Food and Drug Administration, the Health Care Financing Administration, and the Agency for Health Care Policy and Research;

(3) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies.

The independent review organization must base its decision on the information submitted. In making its decision, the organization must consider safety, efficacy, appropriateness, and cost effectiveness.

Deadlines

In the case of an expedited review, the independent review organization must issue a written decision not later than seven days after the filing of the request for review. In all other cases, the independent review organization must issue a written decision not later than 30 days after the filing of the request.

Notice

The independent review organization must send a copy of its decision to the health insuring corporation and the enrollee. If the enrollee's provider or health care facility requested the review, the organization must also send a copy of its decision to the provider or facility. The decision must include a description of the enrollee's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

Effect

Under the act, the health insuring corporation must provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the enrollee's

contract. The act specifies that the decision applies only to the individual enrollee's external review.

Conflicts of interest

The act provides that neither the clinical peer who conducts the review, nor any health care facility with which the clinical peer is affiliated, may have any professional, familial, or financial affiliation with any of the following:

(1) The health insuring corporation or any officer, director, or managerial employee of the corporation;

(2) The enrollee, the enrollee's provider, or the practice group of the enrollee's provider;

(3) The health care facility at which the health service requested by the enrollee would be provided;

(4) The development or manufacture of the principal drug, device, procedure, or therapy proposed for the enrollee.

The act specifies, however, that it does not prohibit a clinical peer from conducting a review if the clinical peer (1) is affiliated with an academic medical center that provides services to enrollees of the health insuring corporation, (2) has staff privileges at a health care facility that provides services to enrollees, or (3) is a participating provider but was not involved with the health insuring corporation's adverse determination.

Cost

The act provides that an enrollee may not be required to pay for any part of the cost of the external review. Instead, the cost of the review must be borne by the health insuring corporation. The act specifies that its provisions against conflicts of interest do not prohibit a health insuring corporation from paying the independent review organization for the review.

Records

The act requires that the health insuring corporation provide to the independent review organization conducting the external review a copy of those records in its possession that are relevant to the enrollee's medical condition and the review. The records are to be used solely for the purpose of conducting the review.

At the request of the independent review organization, the health insuring corporation, enrollee, or the provider or health care facility rendering services to the enrollee must provide any additional information the organization requests to complete the review. The request for additional information must be submitted to the enrollee and the health insuring corporation. If the external review was initiated by a provider or health care facility, a copy of the request must be given to the provider or facility. The request may be made in writing, orally, or by electronic means. If the request is submitted orally or electronically, written confirmation must be provided within five days.

The act provides that an independent review organization is not required to make a decision if it has not received any requested information that it considers necessary to complete a review. If a decision is not made for this reason, the organization must notify the enrollee and the health insuring corporation that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An oral or electronic notice must be confirmed in writing within five days. If the external review was initiated by a provider or health care facility, a copy of the notice must be submitted to the provider or facility.

Termination

The act provides that the health insuring corporation may elect to cover the service requested and terminate the review. The health insuring corporation must notify the enrollee and all other parties involved with the decision by mail or, with the consent or approval of the enrollee, by electronic means.

External review of terminal conditions

(sec. 1751.85)

Continuing law requires each health insuring corporation to establish a reasonable external, independent review process to examine the health insuring corporation's coverage decisions for enrollees with terminal conditions who are denied coverage for drugs, devices, procedures, or other therapies because they are deemed to be experimental or investigational. The act expands the requirements for external review of a decision involving a terminal condition by applying requirements that are similar to the act's requirements for external review of a decision involving a nonterminal condition. These provisions include the following:

(1) The enrollee must exhaust the health insuring corporation's internal review process and request the external review not later than 60 days after the corporation provides notice of the results of its internal review.

(2) The review must be requested in writing, except when the enrollee's physician determines that a therapy would be significantly less effective if not promptly initiated, in which case the request may be made orally or by electronic means with written confirmation given within five days.

(3) The review must be conducted by an accredited independent review organization assigned by the Superintendent of Insurance, rather than an academic medical center or other independent entity as prior law required.

(4) The experts on the review panel must have obtained, during the past three years, clinical experience in the treatment being reviewed.

(5) The review panel's experts must be without conflicts of interest, as specified by continuing law and the act. For example, the act prohibits having a professional, familial, or financial affiliation with the health insuring corporation, enrollee, or facility where a recommended or requested therapy would be performed.

(6) An expert reviewer is not required to render an opinion if requested information is not received from the health insuring corporation or physician recommending therapy and the reviewer considers the information necessary to complete the review.

(7) The review panel, in conducting the review, must take into account specified information and other considerations. For example, the panel must consider the enrollee's medical records; standards used by the health insuring corporation to reach its coverage decisions; research findings of government agencies and nationally recognized organizations; medical literature; clinical guidelines adopted by national medical societies; and issues of safety, efficacy, appropriateness, and cost effectiveness.

(8) The health insuring corporation must provide to the review panel a copy of those records in its possession that are relevant to the enrollee's medical condition and the review; however, the corporation is no longer required to give the enrollee and the enrollee's physician a copy of the relevant medical records in its possession.

(9) At any time during the review, the health insuring corporation may elect to cover the recommended or requested service and terminate the review. The health insuring corporation is required to notify the enrollee and all other parties involved by mail or, with the enrollee's consent or approval, by electronic means.

Effective date and purpose

(Sections 3, 6, and 7)

The act's requirements regarding internal and external review take effect May 1, 2000. The act specifies that it is to be known as the "Patient Protection Act of 1999," and that it is the General Assembly's intent to provide persons with a means for resolving health care coverage disputes expeditiously and to avoid the need for lengthy and expensive litigation.

Independent review organizations

Accreditation and assignment

(sec. 3901.80)

The act requires the Superintendent of Insurance to accredit independent review organizations for purposes of conducting external reviews. The Superintendent may, in accordance with the Administrative Procedure Act (R.C. Chapter 119.) and in consultation with the Director of Health, adopt rules governing the accreditation process. In developing rules, the Superintendent may take into consideration the standards established by national organizations that accredit organizations providing expert reviews and related services. The Superintendent, after reviewing the accreditation process used by a national organization, is authorized by the act to determine that the organization's accreditation constitutes the Superintendent's accreditation. The act prohibits the Superintendent from accrediting any independent review organization that is operated by a national, state, or local trade association of health benefit plans or health care providers.

The act requires each independent review organization to use the services of clinical peers outside the staff of the independent review organization to conduct external reviews. It prohibits a health insuring corporation or enrollee from choosing or controlling the choice of the clinical peers.

The act requires the Superintendent of Insurance to maintain a randomly organized roster of accredited independent review organizations for purposes of assigning organizations to conduct external reviews. The Superintendent may adopt rules governing the assignment of independent review organizations. The rules must be adopted in accordance with the Administrative Procedure Act.

On receipt of a request by a health insuring corporation, the Superintendent must randomly assign two accredited independent review organizations. The

corporation must select one of the assigned organizations to conduct the external review.

The act prohibits any health insuring corporation from engaging in a pattern of excluding a particular review organization based on previous findings on behalf of enrollees. If the Superintendent makes such a finding, the act provides that the pattern of exclusion is an "unfair trade practice."

Immunity

(sec. 3901.84)

The act provides that an independent review organization and any medical expert or clinical peer the organization uses in conducting an external review is not liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review. The act specifies that this provision does not grant immunity from civil liability and professional disciplinary action to an independent review organization, medical expert, or clinical peer for an action that is outside the scope of the authority granted by the act.

Information reporting

(sec. 3901.82)

The act requires each independent review organization that conducts external reviews to make annual reports to the Superintendent of Insurance in a format prescribed by the Superintendent. The reports must include the following information:

- (1) The number of reviews conducted;
- (2) The number of reviews decided in favor of enrollees and the number decided in favor of health insuring corporations;
- (3) The average time required to conduct a review;
- (4) The number and percentage of reviews in which a decision was not reached in the time required by the act;
- (5) A summary of the diagnoses, drugs, devices, services, procedures, and therapies that have been the subject of external review;

(6) The costs associated with external reviews, including the rates charged by the independent review organization to conduct the reviews;

(7) The medical specialty or type of provider used to conduct each external review, as related to the specific medical condition of the enrollee;

(8) Any additional information on the consideration and disposition of external reviews, as the Superintendent may require through the adoption of rules under the Administrative Procedure Act.

The Superintendent of Insurance is required by the act to compile and publish annually the information collected and report the information to the Governor, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, and the chairs and ranking minority members of the House and Senate committees with jurisdiction over health and insurance issues.

Confidentiality of medical records

(secs. 3901.82(B) and 3901.83)

With regard to the information received by the Superintendent of Insurance under the act's provisions requiring independent review organizations to submit annual reports, the act requires that the Superintendent comply with applicable state and federal laws related to the confidentiality of medical records. The act further provides that when the Superintendent receives for any reason a record containing information on the medical history, diagnosis, prognosis, or medical condition of a patient, regardless of the source, the Superintendent must maintain the confidentiality of the record. The act specifies that the record in the Superintendent's possession is not subject to inspection and copying as a public record, except to the extent that information from the record is used in preparing the annual reports that the act requires the Superintendent to submit to the Governor and members of the General Assembly.

Interrelationship of reviews

(secs. 1751.81(F)(2) and (H)(3), 1751.811, 1751.82(B), and 1751.83)

The act includes provisions that specify the relationship between utilization review, reconsideration, internal review, and external review. These provisions include the following:

(1) A request for an internal review may proceed if a health insuring corporation fails to meet the time frames specified in continuing law for making

and providing notice of a utilization review determination. The failure is deemed to be an adverse determination for purposes of requesting the internal review. The request may be made by the enrollee, a person authorized to act on behalf of the enrollee, or the enrollee's provider or health care facility. An enrollee may request an internal review without the approval of the provider or facility, but a provider or facility may not request the review without the enrollee's consent. An enrollee need not be granted an internal review based on a health insuring corporation's failure to make a timely utilization review determination, if the delay is caused by the failure of a health care facility, provider, or enrollee to release all necessary information, in which case the health insuring corporation must notify the enrollee in writing of the reason for the delay.

(2) On completion of a reconsideration, the enrollee, a person authorized to act on behalf of the enrollee, or the provider or health care facility may request an internal review. A request for internal review may not be made by a provider or health care facility unless the enrollee has consented. A reconsideration is not a prerequisite to an internal or external review of an adverse determination.

(3) Failure by a health insuring corporation to provide a written response within the time frames applicable to a request for internal review is considered a denial by the health insuring corporation for purposes of an enrollee's opportunity to request an external review.

(4) In lieu of performing utilization review, providing a reconsideration, or conducting an internal review, a health insuring corporation may afford an enrollee an opportunity for an external review. If an external review is conducted under this provision, the health insuring corporation is not required to afford the enrollee an opportunity for the reviews that were disregarded, unless new clinical information is submitted to the health insuring corporation.

Penalties

(sec. 1751.35)

The act authorizes the Superintendent of Insurance to revoke or suspend a health insuring corporation's certificate of authority to do business in Ohio if the corporation fails to comply with the laws applicable to utilization review, internal review, and external review.

Legal actions

(sec. 1751.87)

The act specifies that nothing in it may be construed to create a cause of action against any of the following:¹

(1) An employer that provides health care benefits to employees through a health insuring corporation;

(2) A clinical peer, medical expert, or independent review organization that participates in an external review;

(3) A health insuring corporation that provides coverage for benefits in accordance with an independent review organization's decision.

Evidence

(sec. 1751.88)

The act provides that, consistent with the Rules of Evidence, a written decision or opinion prepared by or for an independent review organization as part of an external review is admissible in any civil action related to the coverage decision that was the subject of the decision or opinion. The independent review organization's decision or opinion is to be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

The act also provides that, consistent with the Rules of Evidence, any party to a civil action related to a health insuring corporation's coverage decision involving an investigational or experimental drug, device, or treatment may introduce into evidence any applicable Medicare reimbursement standards.

Consumer information

(secs. 1751.11(B) and (D) and 1751.33)

Continuing law provides that every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that lists at least one telephone number providing the subscriber with continuous access to assistance. The act requires that the telephone number be toll-free and specifies that the access to assistance provided by the number is not access to health care, but to information as to how health care services may be obtained. The act also requires that the identification card or document list at least one toll-free number that, during normal business hours, provides the subscriber with access to information on the coverage available under

¹ A "cause of action" is defined by Black's Law Dictionary, 6th ed., as the fact or facts that give a person a right to judicial redress or relief against another.

the subscriber's health plan and information on the health plan's internal and external review processes.

Continuing law requires each health insuring corporation to provide to its subscribers, by mail, a description of the health insuring corporation, its method of operation, its service area, and its complaint procedure. Under the act, the description must include a description of the health insuring corporation's utilization review, internal review, and external review processes. At the request of or with the approval of the subscriber, a health insuring corporation may provide this information by electronic means rather than mail.

Under continuing law, every subscriber of a health insuring corporation is entitled to a document that sets out the coverage or other rights the subscriber is entitled to under the subscriber's health plan. The act provides that this "evidence of coverage" must include a clear, concise, and complete statement of the following: (1) the availability of health care plan information through a toll-free telephone number, and (2) the utilization review, internal review, and external review procedures available to the enrollee.

Medicare and Medicaid exclusions

(sec. 1751.89)

The act specifies that its provisions regarding internal and external reviews do not apply to participants in the Medicare+Choice program or to recipients of Medicaid.

Access to obstetricians and gynecologists

(sec. 1753.13)

The act provides that every individual or group health insuring corporation policy, contract, or agreement that provides basic health care services but does not allow direct access to obstetricians or gynecologists must permit a female enrollee to obtain covered obstetric and gynecological services from a participating obstetrician or gynecologist without obtaining a referral from the enrollee's primary care provider.

The act prohibits an individual or group health insuring corporation policy, contract, or agreement from limiting the number of allowable visits to a participating obstetrician or gynecologist. A health insuring corporation may, however, require a participating obstetrician or gynecologist to comply with the health insuring corporation's coverage protocols and procedures, including utilization review, for obstetric and gynecological services.

A health insuring corporation policy, contract, or agreement may not impose additional copayments for directly accessed obstetric and gynecological services, unless the policy, contract, or agreement imposes additional copayments for direct access to any participating provider other than a primary care provider.

COVERAGE DECISIONS UNDER SICKNESS AND ACCIDENT POLICIES AND PUBLIC EMPLOYEE BENEFIT PLANS

External reviews

(secs. 3923.66, 3923.67, 3923.68, 3923.681, 3923.69, 3923.70, 3923.75, 3923.76, 3923.77, 3923.78, and 3923.79)

The act extends to sickness and accident insurers and public employee benefit plans the same processes for external review of coverage decisions that continuing law and the act applies to health insuring corporations. The provisions applicable under the act to insurers and public plans include the following:

(1) The Superintendent of Insurance is required to establish a system to review coverage decisions that involve the terms of a sickness and accident policy or certificate or a public employee benefit plan.

(2) If review of a coverage decision requires resolution of a medical issue, the external review must be conducted by an independent review organization that has been accredited by the Superintendent.

(3) An individual is eligible to have an external review of medical necessity only if the proposed service will cost the individual more than \$500 if it is not covered and the review is requested not later than 60 days after the Superintendent says the issue requires resolution of a medical issue.

(4) Separate procedures apply to expedited external reviews and external reviews when a terminal condition is involved.

(5) The external review is conducted by an independent review organization selected by the insurer or public plan from one of two organizations assigned by the Superintendent. A pattern of excluding a particular independent review organization is deemed by the act to be an "unfair trade practice."

(6) The independent review organization conducting the review must use clinical peers with expertise in the treatment of the medical condition being reviewed, take into account specified criteria in making a decision, and avoid specified conflicts of interest.

(7) The cost of an external review is not to be borne by the individual, but by the insurer or public plan.

With respect to sickness and accident insurers, the act specifies penalties that may be imposed for violating the act's external review requirements. The most severe penalty is suspension or revocation of an insurer's license to transact business in Ohio. In lieu of suspension or revocation, however, the act permits the Superintendent to levy an administrative penalty of not more than \$100,000 per violation. The Superintendent is authorized to notify an insurer that a violation has occurred or is threatened, and to give the insurer an opportunity to correct or prevent the violation. The Superintendent is also given authority to issue cease and desist orders, violators of which may be prosecuted by the Attorney General.

Access to emergency services

(sec. 3923.65; Sections 3 and 4)

Under the act, every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage is required to cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services. The act also provides that every policy or certificate furnished by an insurer in connection with any sickness and accident insurance policy must provide information regarding the following: (1) the scope of coverage for emergency services, (2) the appropriate use of emergency services, including the use of the 9-1-1 system and other telephone access systems utilized to access prehospital emergency services, and (3) any copayments for emergency services. The act's emergency services requirements begin with policies that are issued, issued for delivery, or renewed on or after April 11, 2000.

"Emergency services" is defined by the act as: (1) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition, (2) such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital. "Emergency medical condition" is defined by the act as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of

immediate medical attention to result in any of the following: (1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Policies affected

(secs. 3923.65(D) and 3923.66(B))

The act specifies that its requirements regarding external review and coverage of emergency services do not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, Medicare, Tricare, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of Workers' Compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. With respect to emergency services, the act provides that its coverage requirement does not apply to coverage under a one-time limited duration policy of no longer than six months.

OHIO INCOME TAX DEDUCTIONS

Health and long-term care insurance

(sec. 5747.01(A)(11) and (12) and (S)(9))

Under the act, a state income taxpayer may deduct amounts paid for medical care insurance and long-term care insurance, as long as the taxpayer is not eligible to participate in an employer-subsidized plan or for Medicare "Part A" (hospitalization) benefits, regardless of whether the taxpayer actually receives those benefits. To be deductible, the expenses must be for medical care insurance or long-term care insurance expenses that are deductible for federal income tax purposes.

If a taxpayer recovers any part of the expenses for which the deduction was claimed, either through a reimbursement or refund of a premium or premium dividend, the recovery is recaptured. If the recovery occurs in the same year the expenses are incurred, then the taxpayer may deduct the expenses only after netting out the refund, reimbursement, or dividend received. If the recovery occurs in any other year, the taxpayer must add the amount of the refund, reimbursement, or dividend to Ohio adjusted gross income. If a taxpayer was required by federal law to add any reimbursement or refund to federal adjusted

gross income because it was related to a previous federal deduction that was not a deduction that reduced the amount of income taxed by Ohio, the taxpayer may deduct the amount added back for federal tax purposes so that no Ohio tax liability will accrue; without such a deduction, the taxpayer would pay Ohio tax on a refund or reimbursement for which no Ohio deduction was ever claimed. This adjustment applies to any federal itemized deduction for expenses recovered by a taxpayer, and not just to medical insurance or long-term care insurance.

Expenses for medical care

The act allows a taxpayer to deduct from adjusted gross income expenses paid during the taxable year for medical care of the taxpayer and the taxpayer's spouse and dependents, to the extent that the expenses exceed 7 1/2% of the taxpayer's federal adjusted gross income. Expenses may be deducted only if (1) they are not otherwise allowable as a deduction or exclusion in computing adjusted gross income for the taxable year, (2) they are not compensated for by insurance or otherwise, and (3) they are deductible for federal income tax purposes. The same recovery provisions that apply under the act to medical insurance and long-term care insurance expenses apply to medical care expenses.

Tax years affected

(Section 5)

The deductions authorized by the act may be taken for expenses incurred on or after January 1, 1999.

COMMENT

The Employee Retirement and Income Security Act (ERISA) of 1974 is a comprehensive federal statute governing the administration of employee benefit plans. ERISA establishes disclosure and funding requirements, standards for eligibility and vesting, and procedures for processing benefit claims. ERISA also limits the authority of states to regulate employer-sponsored health care plans.

ERISA preempts state regulation of employers' self-insured health care plans, but allows states to regulate to a certain extent insurance purchased as part of an employer-sponsored benefit plan. ERISA does not appear to preempt the provision in H.B. 4 that allows a female enrollee to obtain health care services from an obstetrician or gynecologist without a referral. Although federal courts have considered related issues, it is unclear whether ERISA preempts the requirement that an enrollee be granted an independent, external review of a coverage decision.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-20-99	pp. 84-85
Reported, H. Health, Retirement & Aging	06-01-99	pp. 735-736
Passed House (83-14)	06-03-99	pp. 761-768
Reported, S. Health, Human Services & Aging	06-28-99	pp. 702-703
Passed Senate (28-4)	06-28-99	pp. 794-801
House concurred in Senate amendments (84-13)	06-29-99	pp. 1095-1096

99-HB4.123/jc

