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*Bill Analysis*  
*Legislative Service Commission*

## **H.B. 4**

123rd General Assembly  
(As Introduced)

**Reps. Gardner, Tiberi, Buchy, Harris, Allen, Barnes, Barrett, Bender, Boyd, Brading, Britton, Callender, Carey, Cates, Corbin, Core, Coughlin, Evans, Ford, Goodman, Grendell, Haines, Hood, Hoops, Jacobson, Jolivette, Kilbane, Krebs, Krupinski, Maier, Mead, Metelsky, Metzger, Mottley, Myers, O'Brien, Ogg, Olman, Opfer, Padgett, Patton, Pringle, Roman, Salerno, Schuler, Schuring, Smith, Taylor, Terwilleger, Thomas, Willamowski, Williams, Winkler, Womer Benjamin, Young**

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### **BILL SUMMARY**

- Makes a health insuring corporation liable for damages for harm to an enrollee proximately caused by the health insuring corporation's failure to exercise ordinary care in making a health care coverage decision.
- Makes changes to the law governing health insuring corporations to expedite enrollee appeals of health care coverage decisions by health insuring corporations.
- Allows female enrollees to obtain health care services from participating obstetricians or gynecologists without a referral.
- Requires a health insuring corporation to name a licensed physician to act as its medical director.
- Requires a health insuring corporation to provide enrollees with at least one toll-free telephone number for health care plan information and to make additional information available to enrollees.
- Permits deductions from the Ohio income tax for certain medical expenses and long-term care insurance.

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## CONTENT AND OPERATION

### Background

The bill deals with appeals of utilization review decisions by health insuring corporations, liability for those decisions, and other issues related to the operation of health insuring corporations. "Health insuring corporation" is defined under current law as a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic and either supplemental health care services or specialty health care services, through either an open panel or closed panel plan (R.C. 1751.01(N)).<sup>1</sup>

Health insuring corporations are subject to regulation by the Superintendent of Insurance and are required to meet certain credentialing, disclosure, and coverage requirements. A health insuring corporation is not required to perform utilization review; but if it does, current law specifies how the health insuring corporation is to perform utilization review and the time and manner in which it informs enrollees of its utilization review determinations.

Current law defines "utilization review" and "utilization review organization" as follows:

(1) "Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review (R.C. 1751.77(N)).

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<sup>1</sup> "Open panel plan" is defined by current law as "a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers. (R.C. 1751.01(R)(1).)

A "closed panel plan" is "a health care plan that requires enrollees to use participating providers." (R.C. 1751.01(D).)

A "provider" is "any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code . . . ." (R.C. 1751.01(V).)

(2) "Utilization review organization" means an entity that conducts utilization review, other than a health insuring corporation performing a review of its own health care plans (R.C. 1751.77(O)).

**Health insuring corporation liability**

(sec. 1751.88)

**Duty to exercise ordinary care**

Under the bill a health insuring corporation must exercise ordinary care when making utilization review determinations or be subject to liability for damages. In the case of a health insuring corporation, "ordinary care" is defined as that degree of care that a health insuring corporation of ordinary prudence would use under the same or similar circumstances. In the case of a designee of a health insuring corporation, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the designee would use in the same or similar circumstances. In the case of a utilization review organization performing utilization review functions on behalf of a health insuring corporation, "ordinary care" means that degree of care that a utilization review organization of ordinary prudence would use in the same or similar circumstance.

**Liability for damages**

The bill provides that a health insuring corporation is liable for any damages for harm to an enrollee that is proximately caused by a health insuring corporation's failure to exercise ordinary care.<sup>2</sup> With respect to utilization determinations made by a designee of a health insuring corporation or by a utilization review organization that performs utilization review functions on behalf of a health insuring corporation, the health insuring corporation is also liable for damages for harm to an enrollee that is proximately caused by the designee's or utilization review organization's failure to exercise ordinary care (see "**Liability and ERISA**" in COMMENT).

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<sup>2</sup> *The meaning of "proximate cause" has been the subject of considerable litigation. Black's Law Dictionary contains several definitions of "proximate cause," one of which is "the last act contributing to an injury, without which the injury would not have resulted." (Black's Law Dictionary 1225 (6th Ed. 1990).)*

### **Employer liability**

The bill specifies that it does not create any liability on the part of an employer or employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees.

### **Indemnification and hold harmless clauses**

(sec. 1751.89)

The bill prohibits a health insuring corporation from including in a contract with a provider or health care facility an indemnification or hold harmless clause or any other provision that attempts to limit or eliminate the health insuring corporation's liability for any omission of or any action taken by a health insuring corporation that affects the medical care of an enrollee.<sup>3</sup> Any indemnification, hold harmless, or similar provision in a health insuring corporation contract with a health care facility in force on the effective date of the bill is void (see "**Impairment of contracts**" in COMMENT).

### **Utilization review**

(secs. 1751.33 and 1751.78)

### **General requirements**

Current law imposes certain requirements on a health insuring corporation that provides or performs utilization review services in connection with its policies, contracts, and agreements providing basic health services and on any designee of the health insuring corporation in connection with its policies, contracts, or agreements of the health insuring corporation providing basic health services.

### **Information on utilization review process**

Current 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. The bill continues that requirement and specifies that each health insuring corporation is to provide to its subscribers a description of its utilization review process for the determination of

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<sup>3</sup> Black's Law Dictionary defines a hold harmless agreement as "a contractual arrangement whereby one party assumes the liability inherent in a situation, thereby relieving the other party of the responsibility." (Black's Law Dictionary 731 (6th Ed. 1990).)

the eligibility of an enrollee for health care services and its procedures governing the standard appeal of an adverse determination.<sup>4</sup>

### **Enrollee requests for utilization review**

Current law provides that a health insuring corporation is responsible for monitoring all utilization review activities carried out by, or on behalf of, the health insuring corporation and for ensuring that all requirements of Ohio law are met. The bill continues that requirement and provides that on an enrollee's request, a health insuring corporation must perform utilization review to determine the eligibility of the enrollee for health care services that are requested by, or have been provided to, the enrollee.

### **Utilization review: procedures and time frames under current law**

(sec. 1751.81(A) to (F)(1))

### **General requirements**

Current law requires a health insuring corporation to maintain written procedures for making utilization review determinations and for notifying enrollees, and participating providers and health care facilities acting on behalf of enrollees, of its determinations. Current law generally requires a health insuring corporation to make initial, concurrent review, and retrospective review determinations within specified time frames and to provide notifications of those determinations to enrollees and to providers or health care facilities within specified time frames.

### **Initial determinations**

For initial determinations, a health insuring corporation must make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination. In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation must notify the

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<sup>4</sup> "Adverse determination" is defined by current law as "a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service covered under a policy, contract, or agreement of the health insuring corporation has been reviewed and, based upon the information provided, the health service does not meet the health insuring corporation's requirements for benefit payment, and is therefore denied, reduced, or terminated" (R.C. 1751.77(A)).

provider or health care facility rendering the health care service by telephone or facsimile within three business days after making the initial certification. In the case of an adverse determination, the health insuring corporation must notify the provider or health care facility rendering the health care services within three business days after making the adverse determination, and must provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.

### **Concurrent review determinations**

For concurrent review determinations, a health insuring corporation must make the determination within one business day after obtaining all necessary information.<sup>5</sup> In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation must notify the provider or health care facility rendering the health care service by telephone or facsimile within one business day after making the certification. In the case of an adverse determination, the health insuring corporation must notify the provider or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and must provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The health care service to the enrollee must be continued, with standard copayments and deductibles if applicable, until the enrollee has been notified of the determination.

### **Retrospective review determinations**

For retrospective review determinations, a health insuring corporation must make the determination within 30 business days after receiving all necessary information.<sup>6</sup> In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing. In the case of an adverse determination, the health insuring corporation must notify the enrollee and the provider or health care facility

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<sup>5</sup> "Concurrent review" is defined under current law as "utilization review conducted during the patient's hospital stay or course of treatment." (R.C. 1751.77(G).)

<sup>6</sup> "Retrospective review" is defined in current law as "utilization review of medical necessity that is conducted after health care services have been provided to a patient." "Retrospective review" does not include "the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment." (R.C. 1751.77(L).)

rendering the health care service, in writing, within five business days after making the adverse determination.

**Expedited review determinations**

Current law provides that the time frames for determinations and notifications are to be followed unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation must maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

**Utilization review: right of appeal**

(sec. 1751.82(F)(2))

The bill does not modify the time frames in current law for initial, concurrent review, or retrospective review determinations or for required notifications to enrollees, providers, or health care facilities. It does, however, authorize an enrollee to proceed with an appeal (see "**Utilization review: procedure for appeals**" below) if the health insuring corporation fails to make a determination and notification within the time frame. The health insuring corporation's failure to make a determination and notification within the appropriate time frame is deemed to be an adverse determination by the health insuring corporation for the purpose of an enrollee's initiation of an appeal.

**Notification procedures: current law and changes**

(sec. 1751.81(G))

Current law requires written notification of an adverse determination to include the principal reason or reasons for the determination, instructions for initiating an appeal or reconsideration of the determination, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation must provide the clinical rationale for the adverse determination in writing to any party who received notice of the adverse determination and follows the instructions for the request. The bill continues these requirements and also provides that the instructions for initiating an appeal of an adverse determination must state that an independent physician must conduct the review of, and issue a decision in, any appeal made under the bill.

### **Information necessary for review and determination**

(sec. 1751.81(H))

Current law requires a health insuring corporation to have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review. If a health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification. The bill continues these provisions and specifies that a health insuring corporation is prohibited from using unreasonable requests for information to delay making a utilization review determination. The bill also provides that an enrollee may not proceed with an appeal based on a health insuring corporation's failure to make a timely determination, if the health insuring corporation's delay in making a determination and notification is caused by the failure of a health care facility, provider, or enrollee to release all necessary information.

### **Utilization review: procedure for appeals**

(sec. 1751.82(A) to (D))

#### **Current law**

In a case involving an initial determination or a concurrent review determination, a health insuring corporation must give the provider or health care service an opportunity to request in writing on behalf of the enrollee a reconsideration of an adverse determination by the reviewer. The reconsideration must occur within three business days after the health insuring corporation's receipt of the written request for consideration and must be conducted between the provider or health care facility rendering the health care services and the reviewer who made the adverse determination. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer.

If the reconsideration process does not resolve the difference of opinion involved, the adverse determination may be appealed by the enrollee or by the provider or health care facility on behalf of the enrollee. Reconsideration is not a prerequisite to a standard or expedited appeal of an adverse determination. The time period allowed for a reconsideration of an adverse determination does not apply if the seriousness of the medical condition of the enrollee requires a more expedited reconsideration. The health insuring corporation must maintain written procedures for making an expedited reconsideration.

### *Changes proposed by the bill*

The bill continues the appeals procedures in current law and in addition requires the Superintendent of Insurance to prescribe by rule adopted pursuant to the Administrative Procedure Act procedures governing the standard appeal of an adverse determination. These procedures must require all of the following:

(1) The review of an appeal must be conducted by a physician that has been retained to review the appeal. The physician must have expertise in the treatment of the enrollee's medical condition. The physician must not have any professional, familial, or financial affiliation with the health insuring corporation and must have no patient-physician relationship or other affiliation with the enrollee who has brought the appeal. This nonaffiliation provision does not preclude the health insuring corporation from paying the physician for the conduct of the review.

(2) An enrollee must not be required to pay for the physician's review of an appeal. The costs of the review must be borne by the health insuring corporation.

(3) The health insuring corporation must provide to the physician conducting the review of an appeal a copy of those medical records in the health insuring corporation's possession that are relevant to the enrollee's medical condition and the appeal. Those records must be used solely for reviewing the appeal.

(4) A written decision must be issued to all parties to an appeal involving a life-threatening disease or condition within three days after the filing of an appeal. "Life-threatening disease or condition" is defined by the bill as a disease or condition for which death is probable unless the course of the disease or condition is interrupted.

(5) A written decision on an appeal not involving a life-threatening disease or condition must be issued to all parties within 14 days after the filing of the appeal.

The bill specifies that a health insuring corporation must provide any coverage required by a physician's decision in an appeal of an adverse determination.

For an enrollee with a terminal condition, the review of an appeal is to be done according to the procedures in current law.<sup>7</sup>

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<sup>7</sup> *Current law requires each health insuring corporation to establish a reasonable external, independent review process to examine the health insuring corporation's*

### **Access to specialists**

(sec. 1753.13)

The bill provides that a health insuring corporation that does not allow direct access to all specialists must permit a female enrollee to obtain health care services from an obstetrician or gynecologist participating in the enrollee's health care plan without obtaining a referral or any other form of prior authorization for the services. These obstetricians and gynecologists must be authorized to provide health care services to a female enrollee in the same manner as the enrollee's primary care provider.

### **Health insuring corporation medical directors**

(sec. 1753.02)

The bill provides that a health insuring corporation must name a person licensed to practice medicine and surgery or osteopathic medicine and surgery to act as the health insuring corporation's medical director.

### **Consumer information**

(sec. 1751.11(B))

Current 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 specifies the health insuring corporation's name. Current law also requires the identification card or document to list at least one telephone number that provides the subscriber with access to health care on a twenty-four-hours-per-day, seven-days-per-week basis.

The bill continues the requirements of current law and also provides that the telephone number must be toll-free and provide information on the coverage available under the subscriber's health care plan and the plan's appeals process.

### **Evidence of coverage filing requirements**

(sec. 1751.11(A) and (C) to (E))

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*coverage decisions for enrollees with terminal conditions. The review must be conducted by experts selected by an independent entity and paid for by the health insuring corporation (R.C. 1753.24).*

### **Current law**

Current law entitles every subscriber of a health insuring corporation to an evidence of coverage for the health plan under which health benefits are provided. "Evidence of coverage" is defined by current law as "any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage or other rights to which such person is entitled under a health care plan." An evidence of coverage or an amendment to an evidence of coverage cannot be delivered, issued for delivery, renewed, or used, until a health insuring corporation files the evidence of coverage or amendment with the Superintendent of Insurance. Current law sets forth a procedure governing the Superintendent's approval or disapproval of a filed evidence of coverage or amendment.

### **Changes proposed by the bill**

Current law generally prohibits the delivery, issuance for delivery, renewal, or use of an evidence of coverage or amendment unless it satisfies certain criteria including the inclusion of certain information. The bill provides that in addition to information that must currently be provided, an evidence of coverage or amendment 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;
- (2) The availability of utilization review for the determination of the eligibility of the enrollee for health care services;
- (3) The enrollee's right to bring an action against the health insuring corporation for harm proximately caused by the health insuring corporation's failure to exercise ordinary care in making health care coverage decisions.

The bill provides that an evidence of coverage may not be delivered, issued for delivery, renewed, or used if it contains provisions that limit an enrollee's right to a reconsideration or appeal of an adverse determination.

### **Ohio income tax deductions for medical insurance and expenses**

(sec. 5747.13)

### **Health insurance**

Current law allows a self-employed taxpayer to deduct health insurance costs from adjusted gross income for the purpose of computing the taxpayer's Ohio income tax. The bill allows any person, whether self-employed or not, to deduct

health insurance costs as long as they are not covered under an employer-sponsored health plan. For self-employed persons, the deduction cannot exceed income from self-employment.

### **Expenses for medical care**

The bill allows a taxpayer to deduct from adjusted gross income expenses paid during the taxable year for medical care of the taxpayer, the taxpayer's spouse, and dependents to the extent that the expenses exceed 7 1/2% of the taxpayer's federal adjusted gross income, the expenses are not otherwise allowable as a deduction in computing adjusted gross income for the taxable year, the expenses are not compensated for by insurance or otherwise, and the expenses are deductible for federal income tax purposes.

### **Long-term care insurance**

The bill provides that a taxpayer may deduct from adjusted gross income the amount paid during the taxable year for long-term care insurance, to the extent the payments are not otherwise deducted in computing adjusted federal gross income or deducted as a medical expense.

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## **COMMENT**

### **Liability and ERISA**

Regulation of employer-sponsored self-insured health care plans is governed primarily by the federal Employee Retirement and Income Security Act of 1974 (ERISA).<sup>8</sup> Even if state law establishes liability on the part of a health insuring corporation, suits against a qualified self-insured employer plan that conducts utilization review may be preempted by ERISA. Under such circumstances, the enrollee would be limited to the much more restrictive remedies afforded by ERISA.

It is unclear, however, to what extent ERISA preempts claims against managed care organizations for negligent utilization review. In 1997, Texas enacted legislation allowing enrollees to sue a managed care organization for medical malpractice. Subsequently, Aetna sued the State of Texas, claiming the Texas law conflicted with ERISA. In September 1998, a federal district court in

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<sup>8</sup> According to the National Conference of State Legislatures, nationally about 40% of employees are subject to ERISA, "Insurer Liability," Federal Health Policy Tracking Service, December 31, 1998.

Texas upheld an enrollee's right to sue a managed care organization for medical malpractice, but the court struck down the state's independent review process for managed care enrollees who are denied treatment by their insurer. *Corporate Health Insurance v. Texas Dept. of Insurance*, No. 97-2072 (D. Tex. September 18, 1998).

### **Impairment of contracts**

Article II, Section 28 of the Ohio Constitution prohibits the General Assembly from enacting laws that impair the obligation of contracts. Under the contracts clause, a law cannot be applied to contracts entered into before the enactment of the law if it changes the contract by eliminating or reducing the obligations of the contract. Section 1751.89 in the bill raises a possible constitutional issue because it appears to operate retroactively. That section of the bill provides that "any indemnification, hold harmless, or similar provision in a health insuring corporation contract with a health care facility, which is in force on the effective date of the bill, is void."

In determining whether a law impairs a contract, Ohio courts apply a three-step balancing test. The first step is to determine whether the law substantially impairs the contractual relationship. If a substantial impairment is found, the second step is to determine whether the state has a significant and legitimate purpose for the legislation. And if the state has a significant and legitimate public purpose, then the last step is to determine whether adjustment of the rights and responsibilities of the contracting parties is of a character appropriate to the public purpose justifying the legislation's adoption. *Smith v. Denihan* (1990), 63 Ohio App.3d 559, 571. A law substantially impairing an obligation of contract may be constitutional if it is reasonable and necessary to serve an important public purpose. *Middletown v. Ferguson* (1986), 25 Ohio St.3d 71, 79.

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## HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-20-99	pp. 84-85

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