David Fogarty *Legislative Service Commission*

Sub. H.B. 4*

123rd General Assembly
(As Reported by H. Health, Retirement & Aging)

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, Winkler, Womer Benjamin, Young**

BILL SUMMARY

- Makes changes to the law governing health insuring corporations to provide for internal and external reviews of health care coverage decisions by health insuring corporations.
- Requires the Superintendent of Insurance to establish a system for determining whether particular services are covered services under health insuring corporation contracts or agreements.
- Allows female enrollees to obtain health care services from participating obstetricians or gynecologists without a referral.
- 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.
- Requires sickness and accident insurers to cover emergency medical services without regard to when the services were rendered or whether the policyholder, the emergency department, or the policyholder's physician obtained prior authorization for the emergency services.

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* *This analysis was prepared before the report of the House Health, Retirement and Aging Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.*

- 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 internal and external review of coverage decisions by health insuring corporations and other issues related to the operation of health insuring corporations. "Health insuring corporation" is defined in 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)).[1] Health insuring corporations are subject to regulation by the Superintendent of Insurance; must meet certain credentialing, disclosure, and coverage requirements; and are required to make coverage decisions within specified time frames.

Health care coverage decisions: procedures and time frames under current law

(sec. 1751.81)

General requirements

Current law requires a health insuring corporation to maintain written procedures for (1) determining whether a requested service is covered under the terms of an enrollee's policy, contract, or agreement, (2) making utilization review determinations, and (3) notifying enrollees, and participating providers and health

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[1] *"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).)

care facilities acting on behalf of enrollees, of its determinations.[2] Current law generally requires a health insuring corporation to make utilization review determinations within specified time frames and to provide notice of those determinations to enrollees and to providers or health care facilities. The bill provides that an enrollee or an authorized person acting on the enrollee's behalf may proceed with a request for an internal review if a health insuring corporation fails to make a determination and notify the enrollee within those time frames.

Current law provides that a health insuring corporation must have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for utilization review. The bill prohibits a health insuring corporation from using unreasonable requests for information to delay making a determination.

The bill also provides that 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 health insuring corporation's delay in making the determination was caused by the failure of the health care facility, provider, or enrollee to release all necessary information. The health insuring corporation must notify the enrollee of the reason for the delay.

Reconsideration

(sec. 1751.82)

Current law allows a provider or health care facility rendering health care the opportunity to request in writing on behalf of the enrollee a reconsideration of a health insuring corporation's utilization review determination. The bill continues this provision and specifies that on completion of a reconsideration, the enrollee, an authorized person acting on behalf of the enrollee, or the provider or health care facility acting on behalf of the enrollee may request an internal review. Reconsideration is not, however, a prerequisite to an internal or external review of a coverage decision.

Enrollee complaints

(sec. 1751.19)

Current law requires a health insuring corporation to establish and maintain a complaint system that has been approved by the Superintendent of Insurance to

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[2] *"Enrollee" is defined in current law as any natural person who is entitled to receive health care benefits through a health insuring corporation.*

provide adequate and reasonable procedures for the resolution of written complaints by enrollees concerning any matter related to services provided by the health insuring corporation. The bill modifies current law to specify that enrollee complaints regarding health care coverage denials are to be handled through the health insuring corporations' internal review procedures.

The bill also provides that the health insuring corporation may establish one system for receiving and reviewing complaints and appeals from enrollees by combining the complaint system with the internal review system described below, as long as the system meets the requirements in the bill and in current law.

Internal review

(sec. 1751.83)

The bill provides that a health insuring corporation must establish an internal review system that has been approved by the Superintendent of Insurance. The internal review system is to provide for review by a clinical peer and include adequate and reasonable procedures for review and resolution of appeals from enrollees concerning coverage decisions, including procedures for verifying and reviewing appeals from enrollees whose medical conditions require expedited review.[3]

The bill 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, except that if the seriousness of the enrollee's medical condition requires an expedited review, the health insuring corporation is required to provide a written response not later than seven days after receipt of the request. The 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.

If the health insuring corporation has denied, reduced, or terminated coverage for a health care 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 health insuring corporation has denied,

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[3] *"Clinical peer" is defined by current law as a physician when an evaluation is made of the clinical appropriateness of a health care service provided by a physician. If the evaluation is to be made of the clinical appropriateness of health care services provided by a provider who is not a physician, "clinical peer" means either a physician or a provider holding the same license as the provider who provided the health care services.*

reduced, or terminated coverage for a health care service on the grounds that the service is not medically necessary, the response must inform the enrollee of the right to request an external review.

The health insuring corporation is required by the bill to make available to the Superintendent of Insurance for inspection copies of all documents related to internal reviews, including medical records, and copies of responses, for three years following completion of the review. Any document or information provided to the Superintendent of Insurance is confidential and is not a public record.

Bypass of reconsideration and internal review

(sec. 1751.811)

The bill specifies that a health insuring corporation that makes an adverse determination may, in lieu of providing a reconsideration and an internal review, afford an enrollee an opportunity for an external review.[4]

Resolution of contractual disputes by the Superintendent of Insurance

(sec. 1751.831)

The Superintendent of Insurance is required by the bill to establish and maintain a system for receiving and reviewing requests for review on behalf of enrollees who have been denied coverage of a health care 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 request from an enrollee or an authorized person, the Superintendent of Insurance must consider whether the health care service is covered under the terms of the enrollee's policy, contract, or agreement, except that the Superintendent is not to conduct a review unless the enrollee has exhausted the health insuring corporation's internal review process. The health insuring corporation and the enrollee or any authorized person acting on the enrollee's behalf are required by the bill to provide the Superintendent with any information

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[4] *"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)).*

required by the Superintendent that is in their possession and is germane to the review.

Unless the Superintendent of Insurance is unable to do so because making the determination requires resolution of a medical issue, the bill provides that the Superintendent is to determine whether the health care service at issue is a service covered under the terms of the enrollee's policy, contract, or agreement. The Superintendent is required to notify the enrollee and the health insuring corporation of its determination or that it is not able to make a determination.

If the Superintendent of Insurance notifies the health insuring corporation that making the determination requires the resolution of a medical issue, the health insuring corporation shall afford the enrollee an opportunity for an external review. If the Superintendent notifies the health insuring corporation that the health care service is a covered service, the health insuring corporation must either cover the service or afford the enrollee an opportunity for external review. If the Superintendent notifies the health insuring corporation that the health care service is not a covered service, the health insuring corporation is not required to cover the service or afford the enrollee an external review.

External review

(secs. 1751.84 and 1751.85)

In addition to the external review procedures that must be established under current law for certain terminally ill enrollees, the bill requires each health insuring corporation to establish external review procedures for appeal of a decision that a health care service sought by an enrollee is not medically necessary.

Eligibility

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

(2) Except in the case of an expedited review, the proposed service, plus 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.

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 health care service is not a service 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 appeals 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;

(4) The enrollee requests an external review later than 30 days after the enrollee's receipt of notice of the result of an internal review.

Requesting an external review

The bill provides that an external review may be requested by the enrollee, an authorized person, the enrollee's provider, or a health care facility rendering the health care service to the enrollee. The enrollee may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not, however, request an external review without the prior consent of the enrollee.

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. An enrollee who makes an oral or electronic request for review must submit to the health insuring corporation written confirmation of the request not later than five days after making it.

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 the health care facility rendering the health care service to the enrollee that 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.

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 of bodily functions;

(3) Serious dysfunction of any bodily organ or part.

Selection of the independent reviewer

The bill provides that the external review is to be conducted by an independent review organization assigned by the Superintendent of Insurance. Neither the health insuring corporation nor the enrollee may choose, or control the choice of, the clinical peer physician or other medical experts.

The independent review organization must use the services of medical experts and clinical peers who have expertise in the treatment of the enrollee's medical condition and clinical experience in the past three years with the service requested or recommended by the enrollee or the enrollee's provider. The external review must be conducted by a single medical expert or clinical peer, unless the health insuring corporation determines that more than one medical expert or clinical peer is needed. The medical expert or clinical peer must hold a license that is not restricted in any manner by the state in which the clinical peer is licensed. The medical expert or clinical peer must not have been disciplined or sanctioned by a hospital or government entity based on the quality of care provided by the clinical 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.

Conflicts of interest

The bill provides that neither the clinical peer 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 health insuring 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 care 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 bill specifies that it does not prohibit a clinical peer from conducting a review under any of the following circumstances:

(1) The clinical peer is affiliated with an academic medical center that provides health care services to enrollees of the health insuring corporation;

(2) The clinical peer has staff privileges at a health care facility that provides health care services to enrollees of the health insuring corporation;

(3) The clinical peer is a participating provider but was not involved in the health insuring corporation's adverse determination.

The bill also provides that a health insuring corporation is not prohibited from paying for the review.

Cost of the review

The bill provides that an enrollee may not be required to pay for any part of the cost of the external review. The cost of the review is to be borne by the health insuring corporation.

Copies of medical records and other information

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

The bill 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.

Termination of external review

On receipt of additional information on an enrollee's medical condition from a provider or health care facility, 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.

Independent review organization's decision

In making its decision, the independent review organization conducting the review must 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 following:

(a) The enrollee's medical records;

(b) 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 United States Food and Drug Administration, the Health Care Financing Administration of the United States Department of Health and Human Services, 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 independent review organization must consider safety, efficacy, appropriateness, and cost effectiveness.

Deadlines for reaching a decision

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 a 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. 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 render health care services to the enrollee who requested the review, the independent review organization must also send a copy of its decision to the enrollee's provider or the health care facility.

Content of the decision

The bill provides that the independent review organization's decision must include a description of the enrollee's condition and the principal reason for the decision and an explanation of the clinical rationale for the decision.

Effect of the decision

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.

External review for enrollees with a terminal condition

Current 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 bill continues the requirements in current law and provides that some of the external review procedures, time frames, and conflict of interest provisions established by the bill are also applicable to external review procedures for enrollees with terminal conditions.

Accreditation of external review organizations

(sec. 1751.90)

The bill provides that the Superintendent of Insurance must accredit independent review organizations. 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 of independent review organizations. In developing rules, the Superintendent may take into consideration the standards established by national organizations providing expert reviews and related services. The bill also provides that the Superintendent must accept accreditation by a national organization recognized by the Superintendent as accreditation by the Superintendent. The Superintendent must not accredit any independent review organization that is operated by a national, state, or local trade association of health benefit plans or health care providers.

The bill provides that each independent review organization must use the services of medical experts or clinical peers outside the staff of the independent review organization to conduct external reviews.

The bill requires the Superintendent of Insurance to maintain a randomly organized roster of accredited external review organizations for purposes of selecting external review organizations to conduct external reviews. On receipt of a request by a health insuring corporation, the Superintendent must randomly assign two external review organizations that are accredited and qualified to conduct the review. The health insuring corporation must select one of the assigned external review organizations to conduct the review.

The bill prohibits any health insuring corporation from engaging in a pattern of excluding a particular review organization based on their findings on behalf of enrollees. If the Superintendent of Insurance makes such a finding, it is an unfair trade practice.

Liability

(sec. 1751.87)

The bill specifies that nothing in the bill is to be construed to create a cause of action against any of the following:

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

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

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

Presumptions

(sec. 1751.88)

The bill 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 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 bill 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.

Information reporting

(sec. 1751.89)

An independent review organization retained by a health insuring corporation to conduct external reviews must annually report the following information to the Superintendent of Insurance in a format prescribed by the Superintendent:

(1) The number of reviews conducted;

(2) The number of reviews decided in favor of enrollees and the number decided in favor of the health insuring corporation;

(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 bill;

(5) Any additional information required by the Superintendent;

(6) A summary of the diagnoses, drugs, devises, services, procedures, and therapies that have been the subject of external review.

The bill provides that the Superintendent of Insurance must comply with applicable state and federal laws related to the confidentiality of medical records.

The Superintendent of Insurance may, in accordance with the Administrative Procedure Act, adopt rules requiring independent review organizations to provide additional information on the consideration and disposition of external reviews.

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

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.[5] 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, during normal business hours, provide the subscriber with access to information on the coverage available under the subscriber's health plan and information on the health plan's internal and external appeals processes.

Information on utilization review, internal review, and external review

(sec. 1751.33)

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, 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.

Evidence of coverage filing requirements

(sec. 1751.11)

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

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[5] *"Subscriber" is defined in current law as a person responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.*

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 utilization review, internal review, and external review procedures available to the enrollee.

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.

Direct access to obstetricians and gynecologists

(sec. 1753.13)

The bill provides that every individual or group health insuring corporation policy, contract, or agreement that provides basic health care services but does not provide 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 bill also provides that no individual or group health insuring corporation policy, contract, or agreement may limit 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.

Access to emergency services under sickness and accident insurance policies

(sec. 3923.65)

The bill provides that every individual policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage must 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. [6]

The bill 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 emergency medical services;

(3) Any copayments for emergency services.

The bill specifies that these requirements 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 under a one-time limited duration policy of no longer than six months; coverage issued as a

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[6] *"Emergency medical services" is defined by the bill 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 or burn center at the hospital.*

"Emergency medical condition" is defined by the bill 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.

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.

Ohio income tax deductions for medical insurance and expenses

Health insurance and long-term care insurance

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

Currently, taxpayers who are self-employed may deduct amounts they pay for medical care insurance, as long as the amount deducted does not exceed earnings from self-employment, and as long as the taxpayer is not eligible to participate in an employer-subsidized plan. Taxpayers receive no Ohio income tax benefit from the existing federal income tax deduction for medical care expenses (which includes premiums paid for health insurance and long-term care insurance), since the federal deduction is an itemized, "above-the-line" deduction--that is, the federal deduction does not reduce the amount of income taxed by Ohio.

The bill permits all taxpayers to 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 eligible for Medicare "Part A" (hospitalization) benefits (whether or not the taxpayer actually receives those benefits). To be deductible for Ohio tax purposes, the expenses must be for medical care insurance or long-term care insurance that is deductible for federal income tax purposes.

If a taxpayer who claims a deduction recovers any part of the expense 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 expense is incurred, then the taxpayer may only deduct the expense 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 previously deducted "above-the-line" item, the taxpayer may deduct the federal addback 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.[7]

The deduction may be taken for expenses incurred on or after January 1, 1999.

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. Expenses may be deducted only if they are not otherwise allowable as a deduction or exclusion in computing adjusted gross income for the taxable year, they are not compensated for by insurance or otherwise, and they are deductible for federal income tax purposes. The same recovery provisions that apply to medical insurance and long-term care insurance expenses apply to medical care expenses.

The deduction may be taken for expenses incurred on or after January 1, 1999.

COMMENT

ERISA

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 the ERISA preempts the requirement that an enrollee be granted an independent, external review of a

[7] *This last adjustment, deducting federal addbacks, applies to any federal itemized deduction for expenses recovered by a taxpayer, and not just to medical insurance or long-term care insurance.*

coverage decision. Dr. Patricia Butler, a nationally recognized expert with whom LSC ERISA staff consulted, called the question a "toss up."

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-20-99	pp. 84-85
Reported, H. Health, Retirement & Aging	---	---

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