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Bill Analysis
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Reps. Gardner, Tiberi, Buchy, Harris, Brading, Callender, Carey, Cates, Corbin, Core, Coughlin, Evans, Goodman, Grendell, Haines, Hood, Hoops, Jacobson, Jolivette, Kilbane, Krebs, Maier, Mead, Metzger, Mottley, Myers, O'Brien, Olman, Padgett, Roman, Salerno, Schuler, Schuring, Terwilleger, Thomas, Willamowski, Winkler, Womer Benjamin, Young, Vesper, Householder, Austria

Sens. Drake, Kearns, Blessing, Johnson, Spada

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 policies, contracts, or agreements.
- Extends to sickness and accident insurers and public employee benefit plans the requirements for external review of coverage decisions.
- Allows women receiving benefits through a health insuring corporation to obtain health care services from participating obstetricians or gynecologists without being referred by primary care physicians.
- Requires a health insuring corporation to provide enrollees with at least one toll-free telephone number for health care plan information,

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

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

- 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.
- Permits deductions from the Ohio income tax for certain medical expenses and long-term care insurance.

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CONTENT AND OPERATION

Overview

The bill expands the requirements for internal and external review of coverage decisions made by health insuring corporations. It extends the requirement for external review of coverage decisions to sickness and accident insurers and to public employee benefit plans. Coverage decisions involving the terms of a contract are ultimately under the purview of the Superintendent of Insurance. Coverage decisions that require the resolution of medical issues are to be handled by independent review organizations. The review organizations must be accredited by the Superintendent of Insurance and are to be assigned to cases in a random manner.

In addition to the internal and external review provisions, the bill establishes requirements for direct access to obstetricians and gynecologists for women receiving coverage from a health insuring corporation, requirements for coverage of emergency department services for persons receiving coverage from a sickness and accident insurer, and an Ohio income tax deduction for medical expenses and long-term care insurance.

Procedures for coverage decisions by health insuring corporations

(sec. 1751.81)

Current law requires a health insuring corporation that engages in "utilization review" to maintain written procedures for making review determinations. "Utilization review" is defined as a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. When a utilization review determination is made, the health insuring corporation must notify the person (or "enrollee") who receives health care benefits through the corporation and the participating provider (a physician or other health professional) or health facility acting on behalf of the enrollee. The bill expands the requirement that a health insuring corporation maintain written procedures for utilization review by requiring that written procedures be maintained for determining whether a requested service is a service covered under the terms of an enrollee's policy, contract, or agreement.

Current law generally requires a health insuring corporation to make a utilization review determination and provide notice of the determination within specified time frames. The bill provides that a request for an internal review may proceed if a health insuring corporation fails to make a determination and provide notice within those time frames. The request for review may be made by the enrollee, by a person authorized to make health care decisions on behalf of the enrollee, such as a parent or guardian, or by the enrollee's provider or health care facility. The bill specifies that an enrollee may request a review without the approval of the provider or facility, but a provider or facility may not request a review without the prior consent of the enrollee.

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 delay is 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)

Under current law, when a health insuring corporation's utilization review results in an adverse determination, the provider or health care facility rendering health care has the opportunity to request a reconsideration of the determination on behalf of the enrollee.¹ The bill continues this provision, with the stipulation that the enrollee must give prior consent to the request for reconsideration. The bill specifies that 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. The bill specifies that reconsideration is not a prerequisite to an internal or external review of an adverse determination.

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 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.

¹ *The bill continues to use "adverse determination" in basically the same sense that current law uses it, but with modifications to account for the bill's inclusion of adverse determinations that result from contractual disputes over coverage. In short, an adverse determination is any determination made by a health insuring corporation or its designee utilization review organization to deny, reduce, or terminate payment for a health service. (R.C. 1751.77(A).)*

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 adverse determinations, including procedures for verifying and reviewing appeals from enrollees whose medical conditions require expedited review.²

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. If the seriousness of the enrollee's medical condition requires an expedited review, however, 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, including the time frames within which the enrollee must request the review, as specified by the bill.

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, 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, 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.

² "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. The bill specifies that the physician may be licensed in Ohio or another state. (R.C. 1751.77(F) and (K).)

Effect of delays caused by the health insuring corporation

(secs. 1751.81(F)(2) and 1751.83)

Failure to meet the deadlines for utilization review is deemed by the bill to be an adverse determination for the purpose of initiating an internal review. The bill also provides that 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 the enrollee's opportunity to request a review by the Superintendent of Insurance or an external review.

Bypass of utilization review, reconsideration, and internal review

(sec. 1751.811)

The bill provides that a health insuring corporation may, in lieu of performing utilization review, providing a reconsideration, or conducting an internal review, afford an enrollee an opportunity for an external review. The bill specifies that if 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.

Resolution of contractual disputes

(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 from or 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 written request from an enrollee or an authorized person, the Superintendent must consider whether the health care 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 are required by the bill to provide the Superintendent with any information required by the Superintendent that is in their possession and is germane to the review.

Unless the Superintendent 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 covered service. The Superintendent is required to notify the enrollee and the health insuring corporation of the coverage determination or that the Superintendent is not able to make a determination.

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 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

(sec. 1751.84)

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 the 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 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.

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 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;

(4) The enrollee requests an external review later than 60 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, a person authorized to act on behalf of the enrollee, 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. When an oral or electronic request for review 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 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 to bodily functions;

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

Conflicts of interest prohibited

The bill provides for the external review to be conducted by an independent review organization that has been accredited by the Superintendent of Insurance and selected from one of two independent review organizations that the Superintendent randomly assigns to the case (see "**Accreditation and assignment**" under "**Independent review organizations**," below). The bill provides that neither the clinical peer used by the independent review organization to conduct 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 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 with the health insuring corporation's adverse determination.

Expertise of the reviewers

(sec. 3901.81)

The independent review organization selected to conduct the review is required by the bill to utilize the services of clinical peers who have expertise in the treatment of the condition of the enrollee and clinical experience in the past three years with the service that has been requested or recommended. The review

is to 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.

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. The bill specifies that its provisions against conflicts of interest do not prohibit a health insuring corporation from paying for the review.

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. A request for additional information may be made in writing, orally, or by electronic means. The independent review organization must submit the request to the enrollee and the health insuring corporation. If a request is submitted orally or electronically, the bill requires that written confirmation of the request be provided within five days. If the external review was initiated by a provider or health care facility, the bill requires that a copy of the request for additional information be submitted to the provider or health care facility.

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. A review organization that does not make a decision for this reason is required under the bill to 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. Oral and electronic notices 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 of external review

The bill 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.

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 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 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 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 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. 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 independent review organization must also send a copy of its decision to the provider or facility.

Content and effect of the decision

The bill provides that the independent review organization's written 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.

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 bill specifies that the decision applies only to the individual enrollee's external review.

External review for enrollees with a terminal condition

(sec. 1751.85)

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 existing requirements for external review of terminal conditions and applies certain provisions that are similar to the bill's provisions for external review of conditions that are not terminal. The provisions that are applied under the bill include the following:

(1) The enrollee must request the review not later than 60 days after the health insuring 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 for review may be made orally or by electronic means and followed by written confirmation within five days.

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

(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 specified conflicts of interest.

(6) The review panel is not required to render a decision if requested information is not received from the health insuring corporation or physician recommending therapy.

(7) The review panel must consider information specified by the bill when conducting the review.

(8) At any time during the review, the health insuring corporation may elect to cover the recommended or requested service and terminate the review.

Legal actions

(sec. 1751.87)

The bill specifies that nothing in it can be construed to create a cause of action against any of the following:³

(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 in accordance with 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 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 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.

³ 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.

Penalties

(sec. 1751.35)

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

Medicare and Medicaid exclusions

(sec. 1751.89)

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

External review procedures applied to sickness and accident insurers and public employee benefit plans

(secs. 3923.66 to 3923.70 and 3923.75 to 3923.79)

The bill creates for sickness and accident insurers and public employee benefit plans a system for external reviews of coverage decisions that is modeled on the bill's requirements applicable to external reviews of coverage decisions made by health insuring corporations. Under these provisions, the Superintendent of Insurance is responsible for receiving requests regarding contractual disputes, while an independent review organization assigned by the Superintendent is made responsible for conducting an external review that requires resolution of a medical issue. As with the system that applies to health insuring corporations, a separate external review procedure is to be used when a case involves a person with a terminal condition.

Independent review organizations

Accreditation and assignment

(sec. 3901.80)

The bill 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 of independent review organizations. 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 bill also provides that the Superintendent may determine that accreditation by a national organization constitutes 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 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 all of the following from choosing, or controlling the choice of, the clinical peers: a health insuring corporation, enrollee, insurer, insured, public employee benefit plan, or plan member.

The bill 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 bill permits the Superintendent to 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, insurer, or public employee benefit plan, the Superintendent must randomly assign two independent review organizations that are accredited. One of the assigned review organizations must be used to conduct the external review.

The bill prohibits any health insuring corporation, insurer, or public employee benefit plan from engaging in a pattern of excluding a particular review organization based on its findings on behalf of enrollees, insureds, or plan members. If the Superintendent of Insurance makes such a finding, the bill provides that it is an "unfair trade practice."

Immunity from civil actions and professional sanctions for reviewers

(sec. 3901.84)

The bill 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 bill 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 bill.

Information reporting

(sec. 3901.82)

Each independent review organization that conducts 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, insureds, and plan members and the number decided in favor of health insuring corporations, insurers, and public employee benefit plans;
- (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) 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 bill to compile and annually publish 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 medical record information received by the Superintendent of Insurance under the bill's provisions requiring independent review organizations to submit information annually, the bill requires that the Superintendent comply with applicable state and federal laws related to the confidentiality of medical records. The bill 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 bill 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 submitted to the Governor and members of the General Assembly.

Consumer information regarding health insuring corporations

(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 lists at least one telephone number providing the subscriber with access to health care on a twenty-four-hours-per-day, seven-days-per-week basis.⁴ The bill modifies this provision by requiring that the telephone number be toll-free and by specifying that the 24-hours-per-day access provided by the number is not access to health care, but access to information as to how health care services may be obtained. The bill 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 the subscriber's health plan and information on the health plan's internal and external review processes.

⁴ "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.

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 this 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(D))

Under current law, every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health plan under which health benefits are provided.⁵ An evidence of coverage or an amendment to an evidence of coverage cannot be delivered, issued for delivery, renewed, or used, unless it had been approved by the Superintendent of Insurance by satisfying certain criteria, including the provision of certain information. In addition to information that must currently be provided, the bill requires an evidence of coverage or amendment to 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.

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 allow direct access to obstetricians or gynecologists must permit a female enrollee

⁵ "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."

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 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.

Access to emergency services under sickness and accident insurance policies

(sec. 3923.65; Sections 3 and 4)

The bill provides that every individual or group 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

⁶ "Emergency 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.

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 prehospital emergency services;
- (3) Any copayments for emergency services.

Application of sickness and accident insurance requirements

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

The bill 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 coverage of emergency services, the bill provides that the requirement does not apply to coverage under a one-time limited duration policy of no longer than six months.

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); Section 5)

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.

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.*

Effective date and purpose of the bill

(Sections 3, 6, and 7)

The bill's requirements regarding internal and external review take effect May 1, 2000. The bill does not delay the effective date of its provisions regarding direct access to the services of obstetricians and gynecologists and to the toll-free telephone number for health plan information.

The bill 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.

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 ERISA preempts the requirement that an enrollee be granted an independent, external review of a coverage decision. Dr. Patricia Butler, a nationally recognized ERISA expert with whom LSC 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	06-01-99	pp. 735-736
Passed House (83-14)	06-03-99	pp. 761-768
Reported, S. Health, Human		



Services & Aging

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