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Bill Analysis
Legislative Service Commission

S.B. 80

123rd General Assembly
(As Introduced)

Sens. Latell, DiDonato, Furney, Espy, Mallory, McLin, Herington

BILL SUMMARY

- Requires certain health insurance and health care policies, contracts, and plans, and the state Medicaid program, to provide coverage for:
 - A second opinion following a recommendation for a mastectomy;
 - The amount of inpatient care following the mastectomy that is recommended by the treating physician;
 - Breast reconstructive surgery;
 - Physician-directed follow-up care related to the mastectomy.

CONTENT AND OPERATION

Overview and application of the bill

In general, the bill requires certain health insurance contracts, policies, plans, and programs to provide coverage for a second opinion following a recommendation for a mastectomy, the amount of inpatient care following the mastectomy that is recommended by the treating physician, breast reconstructive surgery, *and* physician-directed follow-up care related to the mastectomy.

The bill applies to the following:

- (1) Individual and group health insuring corporation policies, contracts, and agreements that provide coverage for a mastectomy and that are delivered, issued for delivery, or renewed in Ohio on or after the bill's effective date;
- (2) Individual and group sickness and accident insurance policies that provide coverage for a mastectomy and that are delivered, issued for delivery, renewed, or used in Ohio on or after the bill's effective date;

(3) Public employee benefit plans that provide coverage for a mastectomy and that are established or modified in Ohio on or after the bill's effective date;

(4) The state Medical Assistance program (Medicaid) as of the bill's effective date. (See Section 2.)

For purposes of the bill, "**mastectomy**" is defined as the surgical removal of all or part of the breast as a result of or as treatment for breast cancer (secs. 1751.671(A)(2), 3923.65(A)(2), and 5111.019(A)(2)).

Mandated coverage

(secs. 1751.671(A)(1) and (B), 3923.65(A)(1) and (B), 3923.66(A), and 5111.019(A)(1) and (B))

The bill requires that coverage be provided for all of the following:

(1) A second opinion on any diagnosis that includes a recommendation for a mastectomy;

(2) The number of hours of inpatient care following a mastectomy that is recommended by the treating physician in consultation with the patient. Services covered as inpatient care must include medical, educational, and such other services that are consistent with standards for inpatient care following that type of surgery.

(3) Physician-directed follow-up care, which includes physical assessment of the patient, education, all medically necessary and appropriate clinical tests, and any other medical services appropriate as follow-up care for a mastectomy.

(4) Breast reconstructive surgery, including one or more prostheses. "**Breast reconstructive surgery**" means surgery performed coincident with a mastectomy or following a mastectomy to reestablish symmetry between the two breasts. (See **COMMENT.**)

Prohibitions and sanctions

(secs. 1751.671(C), 3923.65(C), 3923.66(B), and 5111.019(C))

The bill prohibits health insuring corporations, insurers, public employers, and the Department of Human Services from (1) terminating the participation of a health care professional or facility as a provider solely for making recommendations for inpatient or follow-up care for a particular mastectomy patient that are consistent with the care required to be covered, and (2)

establishing or offering monetary or other financial incentives to encourage a person to decline the inpatient or follow-up care required to be covered.

A violation of either prohibition is "an unfair and deceptive act or practice in the business of insurance." This has the effect of subjecting the violator to civil and administrative penalties and remedies that are presently available to the Superintendent of Insurance and the courts under sections 3901.22 and 3901.221 of the Revised Code.

What the bill does not require

(secs. 1751.671(D), 3923.65(D), 3923.66(C), and 5111.019(D))

The bill states that it does *not* require:

(1) That a policy, contract, plan, or the Medicaid program, cover inpatient or follow-up care that is not received in accordance with the terms of the policy, contract, plan, or program pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services;

(2) That a mastectomy patient stay in a hospital or the inpatient setting for a fixed period of time following surgery;

(3) That a mastectomy be conducted in an inpatient setting.

Mandated benefits restriction

(secs. 1751.671(B), 3923.65(B), and 3923.66(A))

Section 3901.71 of the Revised Code, as enacted by Am. Sub. H.B. 478 of the 119th General Assembly, provides that no mandated health benefits provision contained in a law enacted after January 14, 1993, can be applied to any health benefits arrangement until the Superintendent determines the provision can be applied "fully and equally in all respects" to (1) employee benefits plans subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or its political subdivisions.

The bill exempts its mandated coverage provisions from this restriction.

COMMENT

Under the federal Women's Health and Cancer Rights Act of 1998, all individual and group health plans, including plans subject to ERISA, that provide

medical and surgical benefits with respect to a mastectomy, must also provide coverage for (1) reconstruction of the breast on which the mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and physical complications at all stages of mastectomy, including lymphedemas. Such coverage is to be provided "in a manner determined in consultation with the attending physician and the patient." (Pub. L. No. 105-277.)

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	02-23-99	p. 144

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