



Greg Schwab

## *Bill Analysis*

*Legislative Service Commission*

### **H.B. 128**

124th General Assembly  
(As Introduced)

**Reps. Coates, D. Miller, DePiero, Ford, Britton, S. Smith, Key**

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#### **BILL SUMMARY**

- Requires certain individual and group policies, contracts, and agreements of health insuring corporations and sickness and accident insurers to provide benefits for the expenses of specified examinations, tests, and counseling associated with periodic physical examinations.

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#### **CONTENT AND OPERATION**

##### **Periodic physical examinations**

(secs. 1751.69 and 3923.551)

The bill requires every individual or group health insuring corporation policy, contract, or agreement providing basic health care services to provide benefits for the expenses of certain examinations, tests, and counseling as part of a program of periodic physical examinations. The bill also requires every individual or group sickness and accident insurance policy that provides coverage for the expenses of a program of periodic physical examinations, to include under that coverage, benefits for the expenses of certain examinations, tests, and counseling. "Periodic physical examinations," as used in this bill in connection with health insuring corporation policies, contracts, and agreements, means a periodic review of an enrollee's health status by a provider; as used in this bill in connection with sickness and accident insurance policies, "periodic physical examinations" means the periodic review of an insured's health status by a physician licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

The policies, contracts, and agreements of health insuring corporations and sickness and accident insurers covered by the bill are required to provide the following examinations, tests, and counseling:

(1) For all enrollees and insureds who are at least 20 years old, annual tests to determine the enrollee's or insured's blood hemoglobin, blood pressure, and blood glucose level, and an annual test to determine either the enrollee's or insured's blood cholesterol level or their levels of low-density lipoprotein and blood high-density lipoprotein;

(2) For all enrollees and insureds who are at least 35 years old, a glaucoma eye test every five years;

(3) For all enrollees and insureds who are at least 40 years old, an annual stool examination for the presence of blood;

(4) For all enrollees and insureds who are at least 45 years old, a left-sided colon examination of 35 to 60 centimeters every five years;

(5) For all enrollees and insureds who are at least 18 years old, their recommended immunizations;

(6) For all enrollees and insureds who are at least 20 years old, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being, including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, and testicular self-examination.

The benefits for these examinations, tests, and counseling are to be provided according to the terms of the policy, contract, or agreement.

The bill exempts its coverage mandates from the review otherwise required by section 3901.71 of the Revised Code. Section 3901.71 of the Revised Code requires the Superintendent of Insurance to hold a public hearing to consider any new health benefit mandate contained in a law enacted by the General Assembly. A new mandate may not be applied to policies, contracts, and plans of insurance until the Superintendent determines that the mandate can be applied fully and equally to self-insured employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA), and to employee benefit plans established by the state or its political subdivisions, or their agencies and instrumentalities. ERISA generally precludes state regulation of benefits offered by private self-insured plans.

The bill applies to individual and group health insuring corporation policies, contracts, and agreements delivered, issued for delivery, or renewed in Ohio on or after the bill's effective date, and to individual and group sickness and accident insurance policies, as defined in section 3923.01 of the Revised Code, on or after the bill's effective date.

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## COMMENT

This bill may contain a "mandated benefit" as defined by section 103.144 of the Revised Code. Section 103.145 of the Revised Code, as enacted by the 123rd General Assembly, requires the Legislative Budget Officer to review any bill receiving a second hearing in a standing committee of the house of the General Assembly in which the bill originated to determine whether the bill contains a mandated benefit. If the Legislative Budget Officer determines that the bill includes a mandated benefit, the Legislative Budget Officer is required to arrange for the performance of an independent actuarial review of the mandated benefit. The findings of the actuarial review must be submitted to the chairperson of the committee to which the bill is assigned, and to the ranking minority member of that committee, no later than 60 days after the second hearing of the bill.

The chairperson of a standing committee of either house of the General Assembly may request, at any time, the Legislative Budget Officer to review any bill assigned to that committee in order to determine whether the bill includes a mandated benefit. If the Legislative Budget Officer determines that the bill includes a mandated benefit, the Legislative Budget Officer must arrange for the performance of an independent actuarial review of the mandated benefit in the same manner provided for in section 103.145 of the Revised Code.

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## HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	02-22-01	p. 177

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