Laurel E. Mannion *Legislative Service Commission*

H.B. 265

124th General Assembly
(As Introduced)

Reps. Kearns, Aslanides, Allen, Barnes, Beatty, Brinkman, Britton, Boccieri, Callender, Cirelli, Damschroder, DePiero, Driehaus, Distel, Fedor, Flannery, Hollister, Jerse, Key, Krupinski, Latta, Lendrum, Latell, Metzger, Metelsky, R. Miller, Ogg, Perry, Peterson, Redfern, Rhine, Setzer, Sulzer, Schmidt, Schneider, Sferra, Schaffer, Wilson, Willamowski, Williams, Womer Benjamin, Webster

BILL SUMMARY

- Requires all closed panel plans offered by health insuring corporations to allow enrollees to use nonparticipating providers, and limits the expenses that may be imposed on enrollees using nonparticipating providers to the out-of-pocket expense imposed on enrollees who use participating providers plus a consumer portability surcharge.

- Extends a copayment limitation currently applicable only to basic health care services to all health care services covered by a health insuring corporation.

CONTENT AND OPERATION

<u>Closed panel plans offered by health insuring corporations</u>

(secs. 1751.01(D), 1751.09, and 1751.13(A)(1))

Current law defines a "**closed panel plan**," for purposes of the health insuring corporations law, as a health care plan that requires enrollees to use participating providers.

Under the bill, a health insuring corporation is prohibited from offering a "**closed panel plan**" unless it meets all of the following requirements:

(1) The plan allows enrollees to use nonparticipating providers, as well as participating providers;

(2) The plan requires enrollees using nonparticipating providers to pay both of the following:

- The same copayment, deductible, or other out-of-pocket expense imposed on enrollees who use participating providers;

- A consumer portability surcharge on all covered health care services other than emergency health services to be paid directly to the provider.[1]

(3) The plan does not condition coverage of a covered health care service on an enrollee's use of a participating provider;

(4) The plan does not deny coverage for a covered health care service rendered to an enrollee by a nonparticipating provider who may legally perform that service;

(5) The plan requires each nonparticipating provider who agrees to provide health care services to an enrollee to accept the same fee schedule, quality assurance and utilization review requirements, and adverse determination appeal procedures that apply to the health insuring corporation's participating providers. However, the bill provides that a health insuring corporation's fee schedule does not apply to a nonparticipating provider who, prior to rendering a health care service to an enrollee, discloses to the enrollee that the provider is unwilling to accept the health insuring corporation's reimbursement as payment-in-full for that service and that the enrollee will be responsible for "paying the difference." The bill does not prohibit a health insuring corporation from denying coverage for any health care service rendered by a nonparticipating provider who fails to comply with the fee schedule, utilization review and quality assurance requirements, or adverse determination appeal procedures applicable to participating providers, unless the disclosure required by the bill is made.

The bill provides that these closed panel plan requirements do not prevent a health insuring corporation from providing financial incentives to any participating provider.

Current law requires a health insuring corporation to enter into contracts for the provision of health care services with a sufficient number and type of providers and health care facilities to ensure that all covered health care services are accessible to enrollees from a contracted provider or health care facility. A health insuring corporation is prohibited from refusing to contract with a physician

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[1] *A "consumer portability surcharge" is defined by the bill as the additional out-of-pocket expense that a closed panel plan requires of enrollees who use nonparticipating providers.*

or health care facility based on the physician's osteopathic education or residency program or based on the facility's certification or accreditation by the American Osteopathic Association. The law provides, however, that it cannot be construed "to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract," provided the health insuring corporation's reason for failing to make a benefit payment is not related to the osteopathic education, certification, or accreditation. This provision is eliminated by the bill to conform with the bill's requirement that closed panel plans allow enrollees to use nonparticipating providers--that is, providers who are not under contract.

Amount of consumer portability surcharge

(secs. 1751.091 and 1751.092)

The bill prohibits a health insuring corporation from imposing a consumer portability surcharge on a covered health care service that exceeds 4% of the total cost of providing the service. The total cost of the service is the amount the health insuring corporation agrees to reimburse a provider. In reimbursing the provider, the health insuring corporation is required to deduct the amount of the surcharge.

A health insuring corporation that offers a closed panel plan is prohibited by the bill from including any of the additional costs incurred by the health insuring corporation in connection with enrollee use of nonparticipating providers in the premium rate charged the subscriber; in the copayment, deductible, or other out-of-pocket expense imposed on the enrollees who use participating providers; or in any other fee or expense other than the consumer portability surcharge.

Definition of "open panel plan"

(sec. 1751.01(R)(1))

Current law defines an "**open panel plan**," for purposes of the health insuring corporations law, as a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use nonparticipating providers. Since, under the bill, nonparticipating providers are available to enrollees covered under both "closed panel plans" and "open panel plans," the bill makes a corresponding amendment to the definition of "open panel plan." As amended by the bill, an "open panel plan," is "any health care plan, *other than a closed panel plan*, that . . . allows . . . enrollees to use providers that are not participating providers."

Copayment limitation extended to all covered health care services

(sec. 1751.12(D)(2))

The health insuring corporations law currently provides that a health insuring corporation "may not impose copayment charges on *basic* health care services that exceed thirty per cent of the total cost of providing any single covered health care service, except for physician office visits, emergency health services, and urgent care services." "Basic health care services" does not include *all* health care services that may be offered by a health insuring corporation. The bill replaces "basic" with "covered" in this provision; consequently, the bill makes the current copayment charge limitation applicable to all "covered" health care services, rather than only to "basic health care services."

Application

(Section 3)

The bill applies to health insuring corporation policies, contracts, and agreements that are delivered, issued for delivery, or renewed in this state on or after July 1, 2002.

COMMENT

This bill may contain a "mandated benefit." Pursuant to Sub. H.B. 221 of the 123rd General Assembly, the Legislative Budget Officer of the Legislative Service Commission is required to review each 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 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 healthcare actuarial review of the 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 may, at any time, request that the Legislative Budget Officer review a bill assigned to the chairperson's committee 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 healthcare actuarial review and report the findings of the review no later than 60 days after receiving the chairperson's request. (Secs. 103.144 to 103.147, not in the bill.)

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	05-22-01	p. 445

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