



H.B. 266

124th General Assembly
(As Introduced)

Reps. Hollister, Schmidt, Ford, Cirelli, Rhine, D. Miller, Beatty, Jerse, Carmichael, Otterman, Woodard, Salerno, White, Barrett, Flowers, Olman, Hartnett, Sferra, Distel, Setzer, Jones, Aslanides, Britton, Latell, Lendrum, Redfern, Carano, Seaver, S. Smith, Sulzer

BILL SUMMARY

- Requires health insurance and Medicaid coverage to include benefits for prostate and colorectal examinations and laboratory tests for cancer.
- Requires that the benefits be provided to nonsymptomatic individuals who are younger than 50 and at high risk for prostate or colorectal cancer or are age 50 or older.

CONTENT AND OPERATION

Benefits for prostate and colorectal examinations and laboratory tests

(secs. 1751.69, 3923.81, 3923.82, and 5111.052)

The bill requires health insurance and Medicaid coverage of benefits for the expenses of the following:¹

(1) Prostate examinations and laboratory tests for cancer for any nonsymptomatic individual who is at least age 50 or is less than age 50 and at high risk for prostate cancer according to the most recently published prostate cancer screening guidelines of the American Cancer Society;

¹ *Medicaid is a joint local, state and federal program that provides health care coverage to low income families, children, aged, and disabled persons who meet criteria established by the Social Security Act, federal regulations, the Ohio Revised Code, and state rules. Medicaid covers many services, including hospital, physician, prescription, and long-term care services.*

(2) Colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic individual who is at least age 50 or who is less than age 50 and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society.

The benefits are for examinations and laboratory tests performed in accordance with the most recently published cancer screening guidelines of the American Cancer Society.

Applicability to health insurance coverage

(secs. 1751.69, 3923.81, and 3923.82; Section 2)

The bill applies to the following health insurance coverage:

(1) Individual and group health insuring corporation (HIC) policies, contracts, and agreements providing basic health care services that are delivered, issued for delivery, or renewed in Ohio after the bill's effective date;²

(2) Individual and group sickness and accident insurance policies after the bill's effective date that are delivered, issued for delivery, or renewed in Ohio, other than policies that (a) provide coverage only for specific diseases or accidents and (b) hospital indemnity, Medicare supplement, and other policies that offer only supplemental benefits;

(3) Public employee benefit plans established or modified in Ohio on or after the bill's effective date.

The benefits provided under the bill are subject to the same terms and conditions, including copayment charges, that apply to similar benefits provided under the health insurance policy, contract, agreement, or plan providing the benefits.

Mandated health benefits bills

The benefits provided for in the bill may be considered mandated benefits, which may cause an independent actuarial review of them to be required (see **COMMENT** for an explanation of this requirement). In addition to the possibility

² "Basic health care services" is defined in current law governing HICs as the following services when medically necessary: (1) physician's services, other than certain supplemental services, (2) inpatient hospital services, (3) outpatient medical services, (4) emergency health services, (5) urgent care services, (6) certain diagnostic services, (7) preventive health care services (sec. 1751.01, not in the bill).

of an actuarial review, a bill that establishes a coverage mandate may be subject to the requirements of Am. Sub. H.B. 478 of the 119th General Assembly. The bill exempts its provisions from the requirements of that bill, however.

H.B. 478 provides that no mandated health benefits legislation enacted on or after January 14, 1993 can apply to any health benefits arrangement until the Superintendent of Insurance holds a public hearing and determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA). (Section 3901.71, not in the bill.) ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers that self-insure their benefit programs.

COMMENT

Actuarial review

The 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 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, not 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 the Legislative Budget Officer to 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 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. (Sections 103.144 to 103.147, not in the bill.)

HISTORY

ACTION	DATE	JOURNAL ENTRY
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