



H.B. 318

124th General Assembly
(As Introduced)

Reps. Webster, Peterson, Allen, Carano, Otterman, Flowers, Rhine, Kearns, Seitz, Sullivan, Metzger, Coates, Setzer, Krupinski, Beatty, Sykes, Callender, Hollister, Perry, Fessler, DeWine

BILL SUMMARY

? Requires benefits to be included in health care coverage for the expense of certain formulas whose protein source has been altered to treat inborn errors of metabolism or a gastrointestinal disease or leading to malnutrition or malabsorption.

CONTENT AND OPERATION

Health care benefits for formulas to treat specific diseases and disorders

(secs. 1751.69, 3923.34, and 3923.341)

The bill requires health care coverage to provide benefits for the expense of polypeptide-based or amino-acid-based formulas whose protein source has been extensively or completely hydrolyzed.

The bill establishes several conditions for the required coverage: (1) the formula is prescribed by a physician, (2) the physician furnishes supporting documentation to the health care coverage provider that the formula is required to treat either a diagnosed inborn error of amino acid or organic acid metabolism or a diagnosed disease or disorder of the gastrointestinal tract that leads to malnutrition or malabsorption due to inflammation, protein sensitivity, or inborn errors of digestion, and (3) the formula is the primary source of nutrition as certified by the treating physician by diagnosis.

Applicability of the required benefits

The bill's requirements apply to the following health care coverage providers: (1) individual and group health insuring corporation (HIC) policies, contracts, and agreements delivered, issued for delivery, or renewed in Ohio, (2)

individual, group, and blanket sickness and accident insurance policies delivered, issued for delivery, renewed, or used in Ohio, and (3) public employee benefit plans established or modified in Ohio, which plans provide coverage for other than specific diseases or accidents only. With respect to the physician who must prescribe the formula, participating physicians under the health coverage described in (1) above must make the prescription; a licensed physician is the required prescriber under the other two types of health care coverage.

The requirement that benefits be provided begins with policies, contracts, agreements, and plans that are established, delivered, issued for delivery, renewed, used, or modified, as described under the bill, in Ohio on or after January 1, 2002. With respect to HICs, the bill's requirements do not apply if a policy, contract, or agreement provides coverage for Medicare or Tricare.¹ With respect to sickness and accident insurers, the bill's requirements do not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, Medicare, Medicare supplement, Tricare, long-term care, disability income, credit, dental, vision, or other policy that offers only supplemental benefits.

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT**). Am. Sub. H.B. 478 of the 119th General Assembly 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 (1) employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or its political subdivisions.² (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction.

¹ *Tricare provides medical care coverage for the United States military--its active duty members and their families, retirees and their family members. "Plain talk about Tricare," Thomas F. Carrato, Executive Director, Tricare, August 28, 2001, www.tricare.osd.mil/plaintalk/plain_talk_8.html.*

² *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. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from an insurer or health insuring corporation.*

COMMENT

Actuarial review

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 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
Introduced	06-27-01	p. 717

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