



## **Sub. H.B. 331**

125th General Assembly  
(As Passed by the General Assembly)

**Reps.** Schmidt, Schneider, Hughes, Clancy, Raga, Schlichter, Webster, T. Patton, Grendell, Flowers, Barrett, J. Stewart, Miller, Allen, DeBose, McGregor, Latta, S. Patton, Key, Kearns, Brown, Jerse, Beatty, Harwood, Kilbane, Walcher, Price, G. Smith, S. Smith, Cirelli, Hollister, Reidelbach, Aslanides, Bocchieri, Book, Buehrer, Callender, Carano, Carmichael, Cates, Chandler, Collier, Daniels, DeGeeter, Distel, Domenick, C. Evans, D. Evans, Faber, Gilb, Hagan, Hartnett, Hoops, Koziura, Martin, Mason, Oelslager, Olman, Otterman, Schaffer, Seaver, Setzer, Sferra, Skindell, Slaby, D. Stewart, Strahorn, Sykes, Taylor, Ujvagi, Widener, Widowfield, Willamowski, Wilson, Woodard, Yates

**Sens.** Hagan, Amstutz, Austria, Blessing, Brady, Carey, Coughlin, Dann, Fedor, Fingerhut, Goodman, Harris, Hottinger, Jacobson, Jordan, Mallory, Miller, Mumper, Nein, Padgett, Prentiss, Randy Gardner, Robert Gardner, Roberts, Schuring, Spada, Wachtmann, White, Zurz

Effective date: \*

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## **ACT SUMMARY**

### **SCREENING MAMMOGRAPHY BENEFITS**

- Eliminates the \$85 benefit maximum that applies under certain health insurance policies and plans for screening mammography, and instead provides that the total benefit is not to exceed 130% of the Medicare reimbursement rate in Ohio for screening mammography.
- Requires that the benefit amount be calculated according to the lowest Medicare reimbursement rate when more than one rate applies in Ohio

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\* *The Legislative Service Commission had not received formal notification of the effective date at the time this analysis was prepared. Additionally, the analysis may not reflect action taken by the Governor.*

for a screening mammography or a component of a screening mammography.

- Specifies that, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit and submits a separate claim for that component, a separate payment must be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component.

### **MEDICAL RECORDS FEES**

- Extends to December 31, 2008 the law governing fees for copies of medical records.
- Changes the fees that health care providers and medical records companies may charge for copies of medical records.
- Specifies the persons or entities entitled to free copies of medical records.
- Requires the Director of Health to adjust fees in accordance with the Consumer Price Index not later than January 31, 2006, and requires that the Department of Health make a list of the adjusted fees available on its website.
- Declares an emergency.

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## **CONTENT AND OPERATION**

### **SCREENING MAMMOGRAPHY BENEFITS**

#### **Coverage for screening mammographies**

(R.C. 1751.62, 3923.52, 3923.53, and 3923.54)

#### **Background**

Ohio law requires every health insuring corporation policy, contract, or agreement<sup>1</sup> providing basic health care services that is delivered, issued for

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<sup>1</sup> "Health insuring corporation" means a corporation formed under Revised Code Chapter 1701. (general corporation law) or 1702. (nonprofit corporation law), or the similar laws of another state, that pursuant to a policy, contract, certificate, or

delivery, or renewed; every public employee benefit plan;<sup>2</sup> and every policy of sickness and accident insurance provided by an employer that is established or modified to provide benefits for screening mammography to detect the presence of breast cancer in adult women. Preexisting law also requires every policy of individual or group sickness and accident insurance<sup>3</sup> delivered, issued for delivery, or renewed in Ohio to *offer to* provide such benefits. Excepted from this requirement are individual or group sickness and accident insurance policies that provide coverage for specific diseases or accidents only, and hospital indemnity, medicare supplement, or other policies that offer only supplemental benefits.

**Definition of "screening mammography"**

Under law unchanged except as described in the next paragraph, "screening mammography" is defined as a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes that has an average radiation exposure delivery of less than one rad mid-breast. It includes two views for each breast. The term also includes the professional interpretation of the film, but does not include diagnostic mammography.

The act modifies the definition of "screening mammography" to reflect that the definition includes x-ray examination of the breast using equipment dedicated specifically for mammography, including, *but not limited to*, the x-ray tube, filter, compression device, screens, film, and cassettes.

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*agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan (R.C. 1751.01(N)).*

<sup>2</sup> *"Public employee benefit plan" is not defined in the Revised Code.*

<sup>3</sup> *"Policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both, that is delivered, issued for delivery, renewed, or used in Ohio (R.C. 3923.01).*

### **Sickness and accident insurance coverage**

The act requires every policy of individual or group sickness and accident insurance to provide, rather than offer to provide, benefits for screening mammography.

### **Mammography benefit maximum**

Under prior law the benefit for screening mammography was limited to \$85 per year unless a lower amount was established pursuant to a provider contract.

The act eliminates the \$85 maximum and provides instead that the total benefit for a screening mammography is not to exceed 130% of the Medicare reimbursement rate in Ohio for screening mammography.<sup>4</sup> If there is more than one Medicare reimbursement rate in Ohio for screening mammography or a component of a screening mammography, the reimbursement limit is 130% of the lowest Medicare reimbursement rate in Ohio. The act defines "Medicare reimbursement rate" as the reimbursement rate paid in Ohio under the Medicare program for screening mammography that does not include digitization or computer aided detection, regardless of whether the actual benefit includes digitization or computer aided detection.

If a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit and submits a separate claim for that component, the act requires that a separate payment be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component.

Whereas former law prohibited an institutional or professional provider from seeking or receiving remuneration in excess of the maximum for the mammography screening benefit, the act provides that no provider, hospital, or other health care facility may seek or receive remuneration in excess of the maximum. Approved deductibles and copayments are excepted from this prohibition under the law governing sickness and accident insurance, public employee benefit plans, and employer provided sickness and accident insurance. Former law governing health insurance corporations excepted only approved copayments. The act adds approved deductibles to the exception, making the

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<sup>4</sup> *The total Medicare reimbursement rate for screening mammography in Ohio (CPT code 76092) is \$81.57. The technical component reimbursement rate is \$46.88 while the professional component reimbursement rate is \$35.69. (Telephone interview with Liz Cepero, Health Insurance Specialist, Centers for Medicare and Medicaid Services (May 17, 2004).)*

exception in the health insurance corporation law the same as the exception in the law governing the other forms of health insurance.

## **MEDICAL RECORDS FEES**

### **Changes to medical records fees**

Ohio law requires health care providers<sup>5</sup> and medical records companies<sup>6</sup> to provide patients or their representatives<sup>7</sup> copies of medical records on request. Former law authorized a health care provider or medical records company to charge a patient or the patient's representative the fees for copies of medical records in accordance with the following schedule, effective through December 31, 2004:

- (1) An initial search fee of \$15;
- (2) A per-page fee:
  - (a) For data recorded on paper, \$1 per page for pages one through ten, \$.50 per page for pages 11 through 50, \$.20 per page for pages 51 and higher;
  - (b) For data recorded other than on paper, the actual cost of making the copy.
- (3) The actual cost of postage.

The act changes the fees that may be charged for copies of medical records and establishes two fee schedules. The first applies when the request is from a

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<sup>5</sup> "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner. Health care practitioners include dentists, nurses, optometrists, pharmacists, physicians, psychologists, and other medical professionals. (R.C. 3701.74.)

<sup>6</sup> "Medical records company" means an individual or private entity that stores, locates, or copies medical records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative (R.C. 3701.74).

<sup>7</sup> "Patient's representative" is currently defined as a person to whom the patient has given written authorization to act on the patient's behalf regarding the patient's medical records (R.C. 3701.74).

patient or patient's personal representative.<sup>8</sup> The second applies when the request comes from a person or entity other than a patient or patient's personal representative. The act provides for these schedules to take effect on January 1, 2005 and to remain in effect through December 31, 2008.

The fee schedule for a patient or a patient's personal representative is as follows:

- (1) No records search fee;
- (2) Per-page fee:
  - (a) For data recorded on paper: \$2.50 per page for the first ten pages; \$0.51 for pages 11 through 50; \$0.20 for pages 51 and higher;
  - (b) For data recorded other than on paper: \$1.70 per page.
- (3) Actual cost of postage.

The fee schedule for all other requesters is as follows:

- (1) \$15.35 records search fee;
- (2) Per-page fee:
  - (a) For data recorded on paper: \$1.02 per page for the first ten pages; \$0.51 per page for pages 11 through 50; \$0.20 per page for pages 51 and higher;
  - (b) For data recorded other than on paper: \$1.70 per page.
- (3) Actual cost of postage.

The act requires the Director of Health to adjust the fee schedules annually beginning not later than January 31, 2006 to reflect an increase or decrease in the Consumer Price Index<sup>9</sup> over the previous 12-month period. Individuals may

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<sup>8</sup> *The act defines "patient's personal representative" as "a minor patient's parent or other person acting in loco parentis, a court-appointed guardian, or a person with durable power of attorney for health care for a patient, or the executor or administrator of the patient's estate or the person responsible for the patient's estate if it is not to be probated."*

<sup>9</sup> *The federal Bureau of Labor Standards publishes the Consumer Price Index (CPI) which measures the average change in price for a market basket of goods and services. The CPI is primarily used as an economic indicator, a deflator of other economic series,*

request copies of the adjusted amounts from the Director, and the Department of Health is required to make the list available on its Internet website.

**Persons or entities entitled to free copies of medical records**

The following persons or entities are entitled to one free copy of a patient's medical record:

- (1) The Ohio Bureau of Workers' Compensation;
- (2) The Ohio Industrial Commission;
- (3) The Ohio Department of Job and Family Services;
- (4) The Ohio Attorney General;

(5) A patient or patient's personal representative if the medical record is necessary to support a Social Security disability claim or an application for Supplemental Security Income. (R.C. 3701.741(C).)

The act states that only these persons and entities are entitled to receive a copy without charge.

**Contracting for different fees**

Preexisting law allowed health care providers and medical records companies to contract with certain persons or entities for fees that differ from the current fee schedule. The act reorganizes the statute (R.C. 3701.741) to clarify that the following persons or entities may contract with a health care provider or medical records company for fees that differ from those in the fee schedules:

- (1) A patient, a patient's personal representative, or an authorized person;<sup>10</sup>
- (2) An insurer authorized under Ohio law to do the business of sickness and accident insurance in this state;
- (3) A health insuring corporation operating under Ohio law.

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*and as a means of adjusting dollar values. U.S. Department of Commerce, Bureau of Labor Statistics, <http://www.bls.gov/cpi>, visited 12/2/04.*

<sup>10</sup> *Former law defined "patient's representative" as a person to whom the patient has given written authorization to act on the patient's behalf regarding the patient's medical record. The act changes this term to "authorized person."*



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## COMMENT

The federal Health Insurance Portability and Accountability Act (HIPAA) (104 Public Law 191) requires health care providers and certain persons or entities that deal with protected health information to maintain certain levels of privacy with regard to that information. The federal Department of Health and Human Services (HHS) has adopted rules to implement portions of HIPAA, including rules regarding fees for copies of medical records. A federal rule provides that a patient or a patient's personal representative may be charged fees for only the following costs (45 Code of Federal Regulations § 164.524):

- (1) Copying, including the cost of supplies and labor;
- (2) Postage, when the patient or patient's personal representative requests that the information be mailed;
- (3) Summarizing or explaining the information, if such a summary or explanation is requested by the patient or the patient's personal representative.

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## HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	11-13-03	p. 1159
Reported, H. Health	05-26-04	pp. 2001-2002
Passed House (97-2)	05-26-04	pp. 2019-2020
Reported, S. Health, Human Services & Aging	12-01-04	p. 2347
Passed Senate (29-0)	12-07-04	pp. 2391-2410
House concurred in Senate amendments (93-2)	12-08-04	pp. 2384-2386

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