



## **H.B. 146**

125th General Assembly  
(As Introduced)

**Reps. Schneider, Beatty, Schmidt, Carano, Clancy, DeBose, Flowers, Barrett, Aslanides, Allen, Grendell, Boccieri, Hollister, Cirelli, Hughes, Brown, Brinkman, DePiero, Husted, Distel, Jolivette, Hartnett, Kearns, Domenick, Driehaus, Kilbane, Harwood, Jerse, McGregor, Key, Koziura, Oelslager, Mason, Miller, Olman, Otterman, T. Patton, S. Patton, Peterson, Perry, Price, Schlichter, Redfern, Seaver, Seitz, S. Smith, Setzer, Skindell, D. Stewart, Webster, Sferra, Strahorn, Trakas, Ujvagi, White, Wilson, Williams, Woodard, Young, Yates**

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### **BILL SUMMARY**

- Requires benefits for diabetes equipment, supplies, medication, and self-management education to be included in health care coverage.

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### **CONTENT AND OPERATION**

#### ***Health care benefits for diabetes***

(secs. 1751.69, 3923.71, and 3923.72)

The bill requires health care coverage to provide benefits for the expenses of (1) equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes and (2) diabetes self-management education for the treatment and management of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes.<sup>1</sup>

The bill establishes several conditions for the required coverage. Equipment, supplies, medication, and self-management education must be prescribed by a physician or other licensed individual authorized to prescribe the

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<sup>1</sup> *The bill defines "equipment, supplies, and medication" as (1) medications, equipment, single-use medical supplies, and related devices approved by the U.S. Food and Drug Administration (FDA) and (2) non-experimental medication for controlling blood sugar including prescription oral agents of each class approved by the FDA for the treatment and management of diabetes and a variety of other available drugs of each class.*

items. With respect to the coverage of diabetes self-management education, the bill's other conditions for coverage are as follows:

(1) During the first 12-month period after a patient begins to receive self-management education, the benefits must cover the expenses of ten hours of education, which may include one hour used for the assessment of the patient's training needs, but only if the education includes the completion of an individual diabetes education plan by a physician or other licensed individual with expertise in diabetes care. The benefits must cover the expenses of completing the plan only if the plan is based on the standards for diabetes self-management education as outlined in the American Diabetes Association's standards of care.

(2) In each year following the first year of self-management education, the benefits must cover the expenses for two hours of self-management education as an annual education maintenance program for the patient, but only if the patient is examined by a physician to determine that the patient is diabetic. Coverage for the expenses of the medical exam may not reduce the coverage provided for expenses of the patient's annual education maintenance program.

(3) The coverage must extend to education provided during home visits when the licensed health professional prescribing the education considers home visits to be important in meeting management or treatment goals.

(4) The education must be provided by a health professional with expertise in diabetes care, including an expert who is a dietitian, physician, pharmacist, registered or licensed practical nurse, or another licensed individual.

(5) Coverage must extend to medical nutrition therapy, as long as it is provided by a dietitian.

(6) Coverage must apply to education provided in a group setting, but cannot be limited to group education.

The benefits provided under the bill may be subject to copayments that the Superintendent of Insurance considers appropriate and are consistent with any other benefit provided.

#### **Applicability of the required benefits**

The bill's requirements apply to (1) individual and group health insuring corporation (HIC) policies, contracts, and agreements, (2) individual, group, and blanket sickness and accident insurance policies, other than those that provide coverage only for specific diseases or accidents, and (3) public employee benefit plans. The requirement that benefits be provided begins with policies, contracts,

agreements, and plans entered into, renewed, or modified on or after the bill's effective date.

**Circumstances not covered by the bill**

The bill specifies that it does not do any of the following:

(1) Preclude an individual, employer, or other entity from negotiating for or obtaining benefits that exceed the benefits required by the bill;

(2) Prohibit an individual diabetes education plan from being disclosed to a HIC, insurer, or public employee benefit plan after it requests the plan in writing or by electronic transmission;

(3) Prohibit a HIC, insurer, or public employee benefit plan from discussing an individual diabetes education plan with the patient or with the person who developed the plan;

(4) Prevent a patient from choosing not to seek or accept diabetes self-management education and notifying the HIC, insurer, or public employee benefit plan of that decision. However, if the patient's overall health status deteriorates and the patient's physician determines and provides detailed, documented medical information that the refusal to seek or accept education has been the predominant medical reason for the deterioration, the HIC, insurer, or public employee benefit plan is not required to continue providing benefits for the expenses of diabetes equipment, supplies, and medication until the patient seeks and accepts the education.

(5) Prevent a patient or the physician or other individual who prescribed diabetes self-management education from petitioning a HIC, insurer, or public employee benefit plan for additional coverage of education the prescriber considers medically necessary, if the petition is made in accordance with procedures for internal and external review of coverage decisions;

(6) Interfere with the authority of a health insuring corporation, insurer, or public employee benefit plan to administer health care coverage through a network and to negotiate reimbursements with providers;

(7) Interfere with the authority of a health insuring corporation, insurer, or public employee benefit plan to include in its provider network, for the purposes of administering the benefits required under the bill, individuals with expertise in diabetes care, including dietitians, physicians, pharmacists, registered or licensed practical nurses, or other individuals licensed to provide the benefits required under the bill.

### 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.<sup>2</sup> (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction.

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## **COMMENT**

### Actuarial review

The benefits required by the bill may be considered "mandated benefits."<sup>6</sup> Pursuant to Sub. H.B. 405 of the 124th General Assembly, the chairperson of a standing committee of either house may, at any time, request that the Director of the Legislative Service Commission to review any bill assigned to the chairperson's committee to determine whether the bill includes a mandated benefit. If the Director determines that the bill includes a mandated benefit, the presiding officer of the house that is considering the bill may request the Director to arrange for the performance of an independent healthcare actuarial review of the benefit. Not later than 60 days after the presiding officer's request for a review, the Director must submit the findings of the actuarial review to the chairperson of the

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<sup>2</sup> *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.*

<sup>3</sup> *"Mandated benefit" means the following, considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement: (1) any required coverage for a specific medical or health-related service, treatment, medication, or practice, (2) any required coverage for the services of specific health care providers, (3) any requirement that an insurer or health insuring corporation offer coverage to specific individuals or groups, (4) any requirement that an insurer or health insuring corporation offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees, (5) any required expansion of, or addition to, existing coverage, and (6) any mandated reimbursement amount to specific health care providers (R.C. 103.144, not in the bill).*

committee to which the bill is assigned and to the ranking minority member of that committee. (R.C. 103.144 to 103.146, not in the bill.)

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## **HISTORY**

ACTION	DATE	JOURNAL ENTRY
Introduced	03-26-03	p. 290

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