



Sub. H.B. 331

125th General Assembly

(As Reported by S. Health, Human Services and Aging)

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Sen. Hagan

BILL SUMMARY

SCREENING MAMMOGRAPHY

- 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 for 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 the law governing fees for copies of medical records, which is to cease to be operative at the end of this year, to December 31, 2008.
- Changes the fees that health care providers and medical records companies may charge for copies of medical records.
- Clarifies 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.

CONTENT AND OPERATION

SCREENING MAMMOGRAPHY

Coverage for screening mammographies

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

Background

Every health insuring corporation policy, contract, or agreement¹ providing basic health care services that is delivered, issued for delivery, or renewed in Ohio, every public employee benefit plan,² and every policy of sickness and accident insurance provided by an employer that is established or modified in Ohio must provide benefits for screening mammography to detect the presence of breast

¹ "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 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)).

² "Public employee benefit plan" is not defined in the Revised Code.

cancer in adult women. Every policy of individual or group sickness and accident insurance³ that is delivered, issued for delivery, or renewed in Ohio must *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.

Current law specifies the level of benefits that must be offered for screening mammography, which varies based on a woman's age:

- If a woman is at least age 35, but under age 40, the policy must cover one screening mammography.
- If a woman is at least age 40 but under age 50, the policy must cover either of the following:
 - One screening mammography every two years.
 - If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.
- If a woman is at least age 50 but under age 65, the policy must cover one screening mammography every year.

Benefits for screening mammography must be provided only for screening mammographies performed in a hospital or a facility or mobile mammography screening unit accredited under the American College of Radiology Mammography Accreditation Program.

Definition of "screening mammography"

"Screening mammography" is defined in current law 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

³ *"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).*

for each breast. The term also includes the professional interpretation of the film, but does not include diagnostic mammography.

The bill 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.

Sickness and accident insurance coverage

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

Mammography benefit maximum

Current law provides that the benefits for screening mammography must not exceed \$85 per year unless a lower amount is established pursuant to a provider contract.

The bill 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.⁴ 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 bill 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 bill 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.

⁴ *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).)*

Whereas current law prohibits an institutional or professional provider from seeking or receiving remuneration in excess of the maximum for the mammography screening benefit, the bill 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. Current law governing health insurance corporations excepts only approved copayments. The bill adds approved deductibles to the exception, making the 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 providers⁵ and medical records companies⁶ to provide patients or their representatives⁷ copies of medical records on request. Through December 31, 2004, a health care provider or medical records company may charge a patient or the patient's representative the following fees for copies of medical records:

- (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;

⁵ "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.)

⁶ "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).

⁷ "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).

(b) For data recorded other than on paper, the actual cost of making the copy.

(3) The actual cost of postage.

The bill 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 patient or patient's personal representative.⁸ The second applies when the request comes from a person or entity other than a patient or patient's personal representative. The bill provides for these schedules to be 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.

⁸ *The bill 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."*

The bill 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 Index⁹ over the previous 12-month period. Individuals may 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 bill states that only these persons and entities are entitled to receive a copy without charge.

Contracting for different fees

Current law allows health care providers and medical records companies to contract with certain persons or entities for fees that differ from the current fee schedule. The bill 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;¹⁰

⁹ *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, 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.*

¹⁰ *Current law defines "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. In the bill, this term is changed to "authorized person."*

(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.

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.

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

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