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Bill Analysis
Legislative Service Commission

H.B. 5

126th General Assembly
(As Introduced)

Rep. Raussen

BILL SUMMARY

- Permits small employers to offer health care plans that do not provide benefits otherwise required by law.
- Provides for the operation of health savings accounts in a manner consistent with federal law.
- Places a limit on an insured's liability for copayments and deductibles under a health benefit plan.

CONTENT AND OPERATION

Flexible health benefit plans; rules

(secs. 1731.03, 3924.01, 3924.02, 3924.10, and 3924.15)

An individual or group health benefit plan providing health care benefits to at least two but no more than 50 employees of a small employer, is currently regulated under sections 3924.01 to 3924.14 of the Revised Code, if the health benefit plan meets either of two conditions: (1) any portion of the plan's premium or benefits is paid by the small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by the small employer for any portion of the plan premium, or (2) the plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of computing federally taxable income. Under continuing law, a "health benefit plan" includes hospital and medical expense policies or certificates and health plans issued by "carriers," defined as sickness and accident insurers, health insuring corporations, and multiple employer welfare associations, but excludes policies that provide only limited care, for example: dental and vision care, one-time limited duration policies of no longer than six months, coverage issued as a supplement to liability

insurance, insurance related to workers' compensation laws, medical coverage included under automobile insurance, and "no-fault" liability insurance.

Unless an exception applies, continuing law requires health benefit plans to include all of the Revised Code's mandated health benefits. The bill enacts such an exception, allowing carriers that offer health benefit plans to small employers to offer a new form of health benefit plan to small employers as an option. The bill names the new health benefit plans "flexible health benefit plans." Flexible health benefit plans do not provide one or more mandated health benefits. The bill conditions a carrier's authority to offer flexible health benefit plans to small employers on the carrier also offering a health benefit plan that includes all mandated health benefits. For this purpose, the bill defines a "mandated health benefit" as any coverage, or offering of coverage, that health benefit plans are required to provide under the Revised Code or rules adopted thereunder for the expense of specified services, treatments, screenings, conditions, diseases, medications and drugs, and includes any required coverage or offering of coverage for the reimbursement of the services of a specific category of health care provider. Health benefit plans sold to small employers that are members of a small employer health care alliance are also subject to the provisions governing "flexible health benefit plans" (sec. 1731.03).

The bill requires a carrier that sells flexible health benefit plans to small employers to supply the policyholder with all of the following: (1) a written notice, which the policyholder then must provide to participating employees, that lists each mandated health benefit that is not included in the flexible health benefit plan's coverage, (2) a statement, which the policyholder must sign and return, acknowledging that the flexible health benefit plan does not provide coverage for the mandated health benefits listed on the statement, and (3) a written notice containing the following language in bold, 12-point type:

"NOTICE: THIS FLEXIBLE HEALTH BENEFIT PLAN DOES NOT PROVIDE ONE OR MORE MANDATED HEALTH BENEFITS THAT NORMALLY MUST BE INCLUDED IN A HEALTH BENEFIT PLAN UNDER OHIO LAW. THIS FLEXIBLE HEALTH BENEFIT PLAN MAY PROVIDE MORE AFFORDABLE HEALTH INSURANCE COVERAGE TO YOU, BUT AT THE SAME TIME, IT MAY PROVIDE YOU WITH FEWER BENEFITS THAN NORMALLY ARE INCLUDED IN A HEALTH BENEFIT PLAN."

The statement signed by the policyholder and returned to the carrier, above, must be maintained by the carrier and made available to the Superintendent of Insurance upon request.

The bill authorizes the Superintendent of Insurance to adopt rules in accordance with the Administrative Procedure Act, Chapter 119. of the Revised Code, to implement the law on flexible health benefit plans.

Ohio Health Care Reinsurance Program; categories of providers; rules

Continuing law permits the board of directors of the Ohio Health Care Reinsurance Program to design health benefit plans, which, when sold by a carrier, are eligible for reinsurance under the Ohio Health Care Reinsurance Program. The plans are subject to the Revised Code's mandated health benefit requirements. The bill allows the board to design plans as flexible health benefit plans that are not subject to the Revised Code's mandated health benefit laws.

The bill specifies that the mandates in the Revised Code requiring health benefit plans offered by sickness and accident insurers and multiple employer welfare associations to reimburse, utilize, or consider specific categories of licensed or certified health care practitioners are not applicable to any flexible health benefit plans offered by insurers and multiple employer welfare arrangements.

Specified state and federal laws not affected by the bill

The flexible health benefit plan law does not affect the application of the state and federal laws specified in the bill, or any rules and regulations adopted under those laws. The laws identified by the bill are:

(1) Any section of the Revised Code that requires a carrier to cover or offer coverage to a specific category of individuals or group, including, but not limited to, any section requiring open enrollment, guaranteed issuance of coverage, continuation of coverage, right to renewal, or an option for conversion with respect to an individual or group;

(2) Any federal law or provision of the Revised Code enacted to comply with a federal law, including, but not limited to, the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended;

(3) Those sections of the Revised Code which govern the processing and payment of insurance claims (secs. 3901.38, 3901.381 to 3901.3814, and 3902.11 to 3902.14);



(4) Those sections of the Revised Code which govern the conduct of internal and external reviews when an enrollee or insured is denied benefits under a health insuring corporation or sickness and accident insurance policy, plan, or agreement, and the conduct of utilization reviews of the necessity and appropriateness of health care services provided by health insuring corporations (secs. 1751.77 to 1751.88 and 3923.66 to 3923.70).

(5) The section of the Revised Code which governs access to prescription drugs by enrollees of health insuring corporations (sec. 1753.21).

(The remainder of this analysis discusses proposed changes that would apply to various other types of plans and issuers and not just the new flexible health benefit plan discussed above.)

Health insuring corporation plan deductibles

(sec. 1751.12)

Currently, the Health Insuring Corporation Law, Chapters 1751. and 1753. of the Revised Code, limits the annual deductibles that a health insuring corporation may require its enrollees to pay at \$1,000 per enrollee or \$2,000 per family. Current law permits the Superintendent of Insurance to adopt rules setting different limits for health plans with an employer-sponsored medical savings account, health reimbursement arrangement, or flexible spending account. The bill adds an exception. Under the bill, a health insuring corporation may impose higher deductibles, exceeding the \$1,000 per enrollee and \$2,000 per family, for federally qualified high deductible health plans that are linked to health savings accounts.

Under the bill, deductibles applied by health insuring corporations do not apply to certain preventive health care services, except when the deduction is required in order to qualify a health plan as a high deductible health plan under federal law. A health plan's deductible does not apply to preventive health care services that include, but are not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care. The bill defines "health savings account" and "high deductible health plan" as having the same meanings as in section 223 of the federal Internal Revenue Code.

Reimbursement rate for health benefit plan deductibles

(sec. 3923.81)

The bill limits the amount that enrollees and insureds may be required to pay health care providers and pharmacies "out-of-pocket" or from savings account

funds. Under the bill, if a person is covered by a health benefit plan issued by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement that includes copayment, deductible, or cost-sharing requirements which the enrollee or insured is required to pay, the amount the enrollee or insured can be required to pay to a health care provider or pharmacy is limited to the amount that the insurer, health insuring corporation, or multiple employer welfare arrangement would pay to the provider or pharmacy under applicable reimbursement rates. A person is not prohibited by the bill from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than the reimbursement rates that would otherwise apply. The bill defines, for purposes of this section, a "health benefit plan" as any policy of sickness and accident insurance, or any policy, contract, or agreement covering one or more "basic health care services," "supplemental health care services," or "specialty health care services" as defined in section 1751.01 of the Health Insuring Corporation Law, that is offered or provided by a health insuring corporation or by a sickness and accident insurer or multiple employer welfare arrangement. "Reimbursement rates" means any rates that apply to a payment made by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement for charges covered by a health benefit plan. A "savings account" is defined as a health savings account, health reimbursement arrangement, flexible savings account, medical savings account, or similar account or arrangement.

If an enrollee or insured provides the enrollee's or insured's sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement with a written request for information about any applicable reimbursement rates that affect the enrollee's or insured's copayment, deductible, or cost-sharing requirements, the insurer, health insuring corporation, or multiple employer welfare arrangement, pursuant to the bill, must provide the information within seven days after receiving the request.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-24-05	p. 79

H0005-I-126.doc/jc

