



Greg Schwab

Bill Analysis
Legislative Service Commission

H.B. 78

126th General Assembly
(As Introduced)

Reps. Barrett, Allen, Brown, Carano, Carmichael, Chandler, DeGeeter, Hartnett, Harwood, Healy, Kearns, Key, Koziura, Mason, Miller, Otterman, S. Patton, Perry, Sayre, Skindell, D. Stewart, Taylor, Ujvagi, Williams, Woodard

BILL SUMMARY

- Requires health insuring corporations, sickness and accident insurers, and public employee benefit plans to provide coverage for new tests that screen for the presence of cervical cancer.

CONTENT AND OPERATION

Coverage for cervical cancer screenings

(secs. 1751.62, 3923.52, and 3923.53)

Currently, the Revised Code requires health insuring corporation policies, contracts, and agreements, public employee benefit plans, and sickness and accident insurance policies to provide benefits for cytological screening for the presence of cervical cancer. This requirement applies both to individual and group policies, contracts, and agreements. This requirement does not apply to health insuring corporation policies, contracts, and agreements providing only supplemental or specialty health care services or to sickness and accident insurance policies providing only supplemental benefits, including Medicare supplement policies, or providing coverage limited to specified diseases and accidents.

The bill expands the current requirement to require coverage of additional tests for cervical cancer. Rather than only providing for coverage of cytological screening, the bill requires health insuring corporation policies, contracts, and agreements, public employee benefit plans, and sickness and accident insurance policies to provide benefits for the expense of "examinations and laboratory tests for the screening for the early detection of cervical cancer." The bill defines examinations and laboratory tests for the screening for the early detection of

cervical cancer as conventional pap smear screening, liquid-based cytology methods, and human papilloma virus (HPV) detection methods, as approved by the United States Food and Drug Administration. Continuing law states that health care policies, contracts, and agreements are not required to provide benefits for a cervical cancer screening unless the screening is processed and interpreted in a laboratory certified by the College of American Pathologists or in a hospital defined as such by Chapter 3727. of the Revised Code. The bill adds another requirement, stating that health care policies, contracts, and agreements are not required to provide benefits for an examination or laboratory test screening for the early detection of cervical cancer that is not performed by or on the order of a licensed physician in accordance with the current screening guidelines of the American College of Obstetricians and Gynecologists. The bill does not alter the exception to this requirement granted to health insuring corporation policies, contracts, and agreements providing only supplemental or specialty health care services or to sickness and accident insurance policies providing only supplemental benefits, including Medicare supplement policies, or providing coverage limited to specified diseases and accidents.

The bill exempts its mandate that health care policies, contracts, and agreements provide coverage for additional examinations and laboratory tests that screen for the presence of cervical cancer from the review otherwise required by section 3901.71 of the Revised Code. Section 3901.71 of the Revised Code requires the Superintendent of Insurance to hold a public hearing to consider any provision in a newly enacted law that requires policies, contracts, or plans of health care to cover, or offer coverage, for the expense of any specified service, treatment, or disease. A new mandate may not be applied to policies, contracts, and plans of health care until the Superintendent determines that the mandate can be fully and equally applied both to self-insured employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and to employee benefit plans established by the state, its political subdivisions, or their agencies and instrumentalities. ERISA, however, generally prohibits state regulation of self-insured employee benefit plans.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	02-23-05	p. 232

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