



## **H.B. 419**

126th General Assembly  
(As Introduced)

**Reps. Peterson, Healy, Miller, Hartnett, Yuko, Stewart, D., Perry, Barrett, Otterman, Koziura, Smith, S., Webster, Strahorn, Allen, Skindell, Carano, Chandler**

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### **BILL SUMMARY**

- Requires benefits to be included in health care coverage for the expense of amino-acid-based formulas.

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### **CONTENT AND OPERATION**

#### **Health care benefits for amino-acid-based formulas**

(secs. 1751.69, 3923.34, and 3923.341)

The bill requires health care coverage to provide benefits for the expense of amino-acid-based formulas.

The bill establishes several conditions for the required coverage: (1) in the case of a health insuring corporation, the formula is prescribed by, or taken under the direction of, a participating physician; otherwise, the formula is prescribed by a licensed physician or taken under a physician's direction, (2) the physician furnishes supporting documentation to the health care coverage provider that the formula is required to treat a diagnosed inborn error of amino acid, organic acid, or fatty acid metabolism, and (3) the formula is the primary source of nutrition as certified by the treating physician by diagnosis.

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

The bill's requirements apply to the following health care coverage providers: (1) individual and group health insuring corporation (HIC) policies, contracts, and agreements providing basic health care services that are delivered, issued for delivery, or renewed in Ohio, (2) individual, group, and blanket sickness and accident insurance policies delivered, issued for delivery, renewed, or used in

Ohio, and (3) public employee benefit plans established or modified in Ohio that provide coverage for other than specific diseases or accidents only.

The requirement that benefits be provided begins with policies, contracts, agreements, and plans that are established, delivered, issued for delivery, renewed, used, or modified, as described under the bill, in Ohio on or after January 1, 2006. With respect to HICs, the bill's requirements do not apply if a policy, contract, or agreement provides coverage for Medicare or Tricare.<sup>1</sup> With respect to sickness and accident insurers, the bill's requirements do not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, Medicare, Medicare supplement, Tricare, long-term care, disability income, credit, dental, vision, or other policy that offers only supplemental benefits.

#### **Exemption from H.B. 478 requirements**

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT**). Existing law, Revised Code section 3901.71, 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)<sup>2</sup> and (2) employee benefit plans established or modified by the state or its political subdivisions. The bill includes provisions exempting its requirements from this restriction.

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<sup>1</sup> *Tricare provides medical care coverage for the United States military--its active duty members and their families and retirees and their families. "Plain talk about Tricare," Thomas F. Carrato, Executive Director, Tricare, August 28, 2001, [www.tricare.osd.mil/plaintalk/plain\\_talk\\_8.html](http://www.tricare.osd.mil/plaintalk/plain_talk_8.html).*

<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.*

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## COMMENT

### Actuarial review

The benefits required by the bill may be considered "mandated benefits."<sup>6</sup> Under current law unchanged by the bill, the chairperson of a standing committee of either house may, at any time, request that the Director of the Legislative Service Commission 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 that the Director 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 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     |
|------------|----------|
| Introduced | 11-15-05 |

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<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).