



H.B. 335

127th General Assembly
(As Introduced)

Reps. DeBose, Fende, Stebelton, Ujvagi, Brown, Letson, Yuko, Brady, Yates

BILL SUMMARY

- Requires certain health care insurers and plans, including the state's Medicaid program, to offer to provide benefits for prostate, colorectal, ovarian, and cervical cancer screening examinations and laboratory tests.

CONTENT AND OPERATION

Current law

Current law requires health insuring corporations, sickness and accident insurers, public employee benefit plans, employers that provide sickness and accident insurance for their employees, and Ohio's Medicaid program to provide benefits for the expenses of cytologic screening for the presence of cervical cancer if the screening is processed and interpreted in a laboratory certified by the College of American Pathologists or in a "hospital" as defined in Ohio's Hospital Certification and Accreditation Law (R.C. 3727.01) (R.C. 1751.62, 3923.52, 3923.53, 3923.54, and 5111.024, not in the bill).

Coverage for certain cancer screening examinations and tests

The bill requires health insuring corporations, sickness and accident insurers, public employee benefit plans, and the state's Medicaid program to offer to provide benefits for prostate, colorectal, ovarian, and cervical cancer screening examinations and laboratory tests (R.C. 1751.69, 3923.90, 3923.91, and 5111.026). Under the bill, a health insuring corporation must offer those benefits as supplemental health care service benefits (R.C. 1751.69).

Additionally, the bill requires all employers in Ohio that provide health care benefits, in whole or in part, through a health insuring corporation, sickness and accident insurer, or public employee benefit plan to offer to provide the same coverage for prostate, colorectal, ovarian, and cervical cancer screening examinations and laboratory tests (R.C. 3923.92).

Scope of coverage

If, under the bill, a health insuring corporation, sickness and accident insurer, public employee benefit plan, the state's Medicaid program, or any employer provides the above coverage, that coverage must be provided to any nonsymptomatic individual for whom the most recently published American Cancer Society guidelines recommend screening based on age, health, and other risk factors.¹ (R.C. 1751.69, 3923.90, 3923.91, 3923.92, and 5111.026.)

The bill only requires coverage for the examinations and laboratory tests recommended by, and performed in accordance with, the most recently published American Cancer Society guidelines. Additionally, that coverage may be subject to the same terms and conditions that apply to similar benefits under the policy, contract, or agreement including copayment charges. (R.C. 1751.69, 3923.90, 3923.91, 3923.92, and 5111.026.)

The bill specifies that its requirements would only apply to policies, plans, contracts, and agreements delivered, issued for delivery, renewed, or modified after the effective date of the bill (Section 2).

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

¹ The American Cancer Society's most recent Guidelines for Early Detection of Cervical Neoplasia and Cancer recommends the use of both conventional cervical cytology smears and liquid-based cytology tests for early detection of cervical cancer. The Society also has suggested that the HPV DNA testing with cytology for primary cervical cancer screening appears to be "promising," though when these guidelines were published in 2003 HPV DNA testing was not approved by the FDA. Though the Society did not study the following screening technologies because they were under development or have been deemed to have utility only in low-cost screening settings, the Society lists the following additional cervical cancer screenings: aided visualization, cervicography, computer-assisted screening devices, optical probe devices, self-collected vaginal samples for HPV DNA testing, and spectroscopy/electronic detection devices. Saslow, D., et al., (2002) "American Cancer Society Guideline for Early Detection of Cervical Neoplasia and Cancer." *A Cancer Journal for Clinicians*, 52(6), pp. 342-362.

established or modified by the state or its political subdivisions.² (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction.

COMMENT

Actuarial review

The benefits required by the bill may be considered "mandated benefits."³ 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 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 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.)

HISTORY

ACTION

DATE

Introduced
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10-02-07

² 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.

³ "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).