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Bill Analysis

Legislative Service Commission

S.B. 99

127th General Assembly
(As Introduced)

Sens. Gardner, Coughlin, Bocchieri, Morano, Spada, Schuring, Roberts, Mumper, Mason, D. Miller, Clancy, Padgett, Cafaro, Goodman

BILL SUMMARY

- Requires that HMOs, sickness and accident insurers, and public employee benefit plans, under certain circumstances, provide coverage for diabetes equipment, supplies, medication, and self-management education in the health care coverage or policies they offer.

CONTENT AND OPERATION

Health care benefits for diabetes

(secs. 1751.69(B), 3923.71(B), and 3923.72(B))

The bill requires that sickness and accident insurers, health insuring corporations (HMOs), and public employee benefit plans offer health care coverage for the expenses of the following, when determined to be medically necessary: (1) equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes, (2) medical nutrition therapy, and (3) diabetes self-management education.

The bill's requirements apply to the following: (1) individual and group health insuring corporation (HMOs) policies, contracts, and agreements, (2) individual, group, and blanket sickness and accident insurance policies delivered, issued for delivery, or renewed in this state, other than those that provide coverage for specific diseases or accidents only, for hospital indemnity only, for supplemental Medicare benefits only, or for any other supplemental benefits only, and (3) public employee benefit plans. The requirement that benefits be provided begins with policies, contracts, agreements, and plans entered into, renewed, or modified on or after the bill's effective date. (Section 3.)

Definitions

(secs. 1751.69(A), 3923.71(A), and 3923.72(A))

The bill defines:

"Equipment, supplies, and medication" as (1) non-experimental equipment, single-use medical supplies, and related devices approved by the U.S. Food and Drug Administration (FDA) and (2) non-experimental medication, insulin, glucagons, and insulin syringes for controlling blood sugar approved by the FDA for the treatment and management of diabetes.

"Medical nutrition therapy" as nutritional diagnostic, therapeutic, and counseling services for the purpose of diabetes disease management, provided by a licensed dietician or a nutrition professional pursuant to a physician's referral.

"Diabetes self-management education" as an interactive and ongoing process prescribed by a physician involving a patient with diabetes and the physician or other professional with expertise in diabetes, including the following components: assessment and identification of the patient's diabetes needs and management goals, education and behavioral intervention directed towards helping the patient attain self-management goals, and evaluation of the patient's progress in attaining self-management goals.

Conditions for required coverage

(secs. 1751.69(C), 3923.71(C), and 3923.72(C))

The bill establishes several conditions for the required coverage as it relates to the expenses of self-management education and medical nutrition therapy. The treatment must be prescribed by a physician or other licensed individual authorized to prescribe the items. With respect only to the coverage of diabetes self-management education, the bill's other conditions for coverage are as follows:

(1) During the first 12-month period after a patient begins to receive self-management education, the benefits must cover the expenses of ten hours of education, which may include medical nutrition therapy, in a program based on the standards for diabetes self-management education as outlined in the American Diabetes Association's standards of care.

(2) In each year following the first year of self-management education, the benefits must cover the expenses for two hours of self-management education, one hour of which may be used for medical nutrition therapy, as an annual education maintenance program for the patient, but only if the education is medically necessary and prescribed by a physician or other individual authorized by licensure to prescribe the education. Coverage for the expenses of the medical

examination may not reduce the coverage provided for expenses of the patient's annual education maintenance program.

(3) The education must be provided by a health professional with expertise in diabetes care authorized by licensure to provide the education.

(4) Coverage must extend to medical nutrition therapy, as long as it is provided by a licensed dietitian unless the patient's health plan does not include a dietitian in its network of providers.

(5) Coverage must include the expenses of any diabetes self-management education determined to be medically necessary, whether provided in a group setting, during home visits, or by individual counseling.

The benefits provided under the bill may be subject to copayments that the Superintendent of Insurance considers appropriate and are consistent with any other benefit provided.

Exemptions from coverage

The bill exempts insurers, health insuring corporations, and public employee benefit plans from the required coverage for diabetes self-management education and medical nutrition therapy if certain conditions are met. Coverage is not required for diabetes self-management education and medical nutrition therapy in combination with the offer of coverage for all other listed basic health care services if the Superintendent of Insurance, based on documentation submitted by the HMO, insurer, or plan, makes the following determinations: (1) incurred claims for diabetes self-management education and medical nutrition therapy for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year, and (2) the increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate. 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 established or modified by the state or its political subdivisions. (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.) The bill includes provisions exempting its requirements from this restriction.

COMMENT

Actuarial review

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

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	03-06-07

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