



Ohio Legislative Service Commission

Bill Analysis

Katie Bentley

H.B. 81

128th General Assembly
(As Introduced)

Reps. Boyd, Gardner, Weddington, Mallory, Domenick, Newcomb, Luckie, Miller, Yuko, B. Williams, Murray, Foley, Hagan, Chandler, Harris, Skindell, Oelslager, Okey, Pryor, Phillips, S. Williams, Bolon, Letson, Stewart, Brown, Garrison, Fende, Book, Winburn, Garland, Patten

BILL SUMMARY

- Requires that multiple employer welfare arrangements, health insuring corporations, 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, policies, or plans they offer.

CONTENT AND OPERATION

Health care benefits for diabetes

(secs. 1739.05, 1751.69(B), and 3923.71(B))

The bill requires that health care plans offer 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) multiple employer welfare arrangements that operate group self-insurance programs, (2) individual and group health insuring corporation policies, contracts, and agreements that cover basic health care services, (3) individual and group sickness and accident insurance policies, other than those that provide coverage for specific diseases or accidents only, hospital indemnity, Medicare supplement, Medicare, tricare, long-term care, disability income, a one-time limited duration of not longer than six months, or any other supplemental benefits, and (4) public employee benefit plans. However, the bill's requirements apply

only to 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) and 3923.71(A))

The bill defines:

"Equipment, supplies, and medication" as (1) non-experimental equipment, single-use medical supplies, and related devices and (2) non-experimental medication, insulin, glucagons, and insulin syringes for controlling blood sugar, approved by the U.S. Food and Drug Administration 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) and 3923.71(C))

The bill establishes several conditions for the required coverage as it relates to the expenses of self-management education and medical nutrition therapy. Those conditions for coverage are as follows:

(1) The education must be medically necessary and prescribed by a physician or other licensed individual authorized to prescribe the education.

(2) 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.

(3) 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.

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

(5) 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.

(6) 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.

Exemptions from coverage

The bill exempts multiple employer welfare arrangements, sickness and accident 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 if the Superintendent of Insurance, based on documentation submitted by the multiple employer welfare arrangement, health insuring corporation, 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 multiple employer welfare arrangement's, health insuring corporation's, insurer's or plan's costs for claims and administrative expenses for the coverage of 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 multiple employer welfare arrangement, health insuring corporation, insurer, or plan for the coverage of health care services.

The bill also exempts multiple employer welfare arrangements, insurers, health insuring corporations, and public employee benefit plans from the required coverage for the expenses of medically necessary diabetes medication, equipment, and supplies if

the insured person is covered by an employer-provided supplemental benefit policy that provides comparable benefits for those expenses.

Copayments and deductibles

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

The bill limits copayment and deductible amounts for medically necessary diabetes medication, equipment, and supplies. Under the bill, copayment and deductible amounts for those benefits can be no higher than they would be if provided through a supplemental benefit policy. In policies and plans that are required to cover diabetes medication, equipment, and supplies under the bill and supplemental benefit policies that offer such coverage, copayment and deductible amounts cannot exceed those for other medication, equipment, and supplies covered under the policy or plan.

Exemption from review by the Superintendent of Insurance

The coverage required under this bill may be considered mandated health benefits. Under section 3901.71 of the Revised Code, no mandated health benefits¹ legislation enacted by the General Assembly may be applied to any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.), that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA)² and (2) employee benefit plans established or modified by the state or any political subdivision of the state, or by any agency or instrumentality of the state or any political subdivision of the state. The bill includes a provision that exempts its requirements from this restriction.

¹ Section 3901.71 of the Revised Code defines "mandated health benefits" as any required coverage, or required offering of coverage, for the expenses of specified services, treatments, or diseases under any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits to policyholders, subscribers, or members.

² ERISA is a comprehensive federal statute that governs the administration of employee benefit plans. ERISA generally precludes direct state regulation of benefits offered by private employers but allows state regulation of the business of insurance. Therefore, ERISA preempts the state's ability to require private self-insuring employers to offer to cover certain services.

HISTORY

ACTION

DATE

Introduced

03-18-09

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