



# Ohio Legislative Service Commission

## Bill Analysis

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### Am. H.B. 81

128th General Assembly  
(As Passed by the House)

**Reps.** Boyd and 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, Belcher, Carney, Celeste, DeBose, Dodd, Dyer, Harwood, Heard, Lundy, Moran, Szollosi, Ujvagi, Yates

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## 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, diabetes medical nutrition therapy, and self-management education in the health care coverage, policies, or plans they offer.
- Creates the Small Business Health Care Affordability Task Force to study, review, and consider various aspects of health care in this state, including employees' access to health care through small business employers and the feasibility of applying mandated health benefits to the Medicaid program.

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## CONTENT AND OPERATION

### Health care benefits for diabetes

The bill requires that health care plans provide coverage for the expenses of medically necessary (1) equipment, supplies, and medication for the treatment and management of diabetes, (2) diabetes 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 only 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. (R.C. 1739.05, 1751.01(A)(1)(j), 1751.69(B), and 3923.71(B) and (E) and Section 3.)

## **Definitions**

The bill defines:

"Equipment, supplies, and medication" as including, when determined to be medically necessary (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. The equipment, supplies, and medication must be approved by the U.S. Food and Drug Administration for the treatment and management of diabetes.

"Medical nutrition therapy" means 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" means 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 toward helping the patient attain self-management goals, and evaluation of the patient's progress in attaining self-management goals. (R.C. 1751.69(A) and 3923.71(A).)

## **Conditions for required coverage**

The bill establishes several conditions for the required coverage as it relates to the expenses of diabetes 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 diabetes self-management education, the benefits must cover the expenses of two hours of diabetes self-management education, one hour of which may be used for medical nutrition therapy, as an annual 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 a required 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 only if the therapy 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. (R.C. 1751.69(C) and 3923.71(C).)

### **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. Specifically, coverage is not required for diabetes self-management education and medical nutrition therapy if the Superintendent of Insurance 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.<sup>1</sup> (R.C. 1739.05(B), 1751.69(D), and 3923.71(D).)

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<sup>1</sup> The Superintendent's determination is to be based on documentation and a signed opinion letter from an independent member of the American Academy of Actuaries. The bill requires that the

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 (R.C. 1739.05(B), 1751.69(B)(2), and 3923.71(B)(2)).

### **Copayments and deductibles**

The bill limits copayment and deductible amounts for medically necessary diabetes equipment, supplies, and medication. Specifically, in policies, contracts, agreements, and plans that are required to cover diabetes equipment, supplies, and medication under the bill and supplemental benefit policies that offer such coverage, copayment and deductible amounts cannot exceed those for other equipment, supplies, and medication covered under the policy, contract, agreement, or plan. (R.C. 1751.69(B)(2) and 3923.71(B)(2).)

### **Exemption from review by the Superintendent of Insurance**

The coverage required under this bill may be considered mandated health benefits. Under R.C. 3901.71, no mandated health benefits<sup>2</sup> 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)<sup>3</sup> 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. (R.C. 1751.69(B) and 3923.71(B).)

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documentation and opinion letter be submitted to the Superintendent by the multiple employer welfare arrangement, health insuring corporation, insurer, or plan.

<sup>2</sup> R.C. 3901.71 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.

<sup>3</sup> 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.

## The Small Business Health Care Affordability Task Force

The bill creates the Small Business Health Care Affordability Task Force. The Task Force must consist of at least six members: three members of the House of Representatives, two of whom are appointed by the Speaker of the House of Representatives and one of whom is appointed by the Minority Leader of the House of Representatives, and three members of the Senate, two of whom are appointed by the President of the Senate and one of whom is appointed by the Minority Leader of the Senate. The Speaker of the House of Representatives and the President of the Senate must each designate one of those members to serve as a co-chair of the Task Force.

The bill requires that the Task Force start its organizational meeting not later than 30 days after the effective date of the bill. At that meeting, the Task Force can appoint up to five additional members who represent small business employers or employees or who are otherwise relevant to the duties of the Task Force. None of these additional members can be a member of the General Assembly.

The Task Force must do all of the following:

(1) Study the potential benefits of state tax incentives for small businesses that provide health insurance coverage for employees;

(2) Study potential state incentives for businesses to offer health wellness and disease prevention programs;

(3) Review employer health insurance tax incentives and wellness programs in other states and analyze whether such state policies would encourage greater affordability of employer-provided health insurance coverage and support employers in maintaining and expanding the workforce in Ohio;

(4) Consider federal legislation regarding the provision of health insurance by small businesses, including the proposed "Healthy Workforce Act of 2009"<sup>4</sup> and "Small Business Health Options Program Act of 2009,"<sup>5</sup> and the potential impact of such federal legislation on Ohio's small businesses;

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<sup>4</sup> The title of the "Healthy Workforce Act of 2009" states that the Act amends the Internal Revenue Code of 1986 "to provide a tax credit to employers for the costs of implementing wellness programs, and for other purposes" (H.R. 1897 and S. 803, 111th Cong. (2009)).

<sup>5</sup> The title of the "Small Business Health Options Program Act of 2009" states that the Act amends the Public Health Service Act to "establish a nationwide health insurance purchasing pool for small businesses and the self-employed that would offer a choice of private health plans and make health coverage more affordable, predictable, and accessible" (H.R. 2360 and S. 979, 111th Cong. (2009)).

(5) Study the cost and feasibility of applying mandated health benefits as defined in R.C. 3901.71 to the Medicaid program.<sup>6</sup>

Under the bill, the Task Force must report its findings and any recommendations to the Speaker of the House of Representatives, Minority Leader of the House of Representatives, President of the Senate, Minority Leader of the Senate, and Governor not later than six months following its initial organizational meeting. On submission of that report, the Task Force ceases to exist. (Section 4.)

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## HISTORY

ACTION	DATE
Introduced	03-18-09
Reported, H. Health	06-16-09
Passed House (58-38)	12-08-09

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<sup>6</sup> Under R.C. 3901.71, "mandated health benefits" means 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.