



Ohio Legislative Service Commission

Bill Analysis

Katie Bentley

H.B. 332

128th General Assembly
(As Introduced)

Reps. Stewart, Skindell, Slesnick, Foley, Yuko, Letson, Hagan, Harris, Garland

BILL SUMMARY

- Prohibits certain insurers from limiting or excluding coverage for prescription contraceptive drugs and devices and related outpatient services.

CONTENT AND OPERATION

Contraceptive benefits

The bill prohibits sickness and accident insurance policies, public employee benefit plans, and health insuring corporation policies, contracts, and agreements from doing either of the following:

(1) Limiting or excluding coverage for prescription contraceptive drugs or devices approved by the United States Food and Drug Administration, if the policy, contract, agreement, or plan provides coverage for other prescription drugs or devices;

(2) Limiting or excluding coverage for physician-directed outpatient services that are related to the provision of such drugs or devices, if the policy, contract, agreement, or plan provides coverage for other outpatient services rendered by a provider. (R.C. 1751.69(A) and 3923.85(A).)

The coverage required under the bill must be subject to the same terms and conditions, including copayment charges that apply to similar coverage provided under the policy, contract, agreement, or plan. (R.C. 1751.69(B) and 3923.85(B).) Additionally, the bill's requirements apply only to policies, contracts, agreements, and plans that are delivered, issued for delivery, renewed, established, or modified after the bill's effective date (Section 2).

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. (R.C. 1751.69(A) and 3923.85(A).)

HISTORY

ACTION	DATE
Introduced	10-27-09

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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.