Ohio Legislative Service Commission

Bill Analysis

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S.B. 233

129th General Assembly
(As Introduced)

Sens. Oelslager, Schiavoni, Tavares

BILL SUMMARY

- Prohibits health plan issuers from imposing copayment or coinsurance charges for physical or occupational therapy that is greater than that of copayment or coinsurance charges for services provided by a primary care physician for an office visit.
- Prohibits a health plan issuer from entering into a contract with an intermediary organization for the provision of health services from a provider that differs from an already existing contract between the health plan issuer and the provider.
- Expressly includes intermediary organizations within the definition of contracting entity in the Health Insurance Contract Law.
- Clarifies that if a participating provider properly objects to the material amendment of a health care contract, and there is no resolution, and neither party terminates the health care contract, the material amendment does not become part of the existing health care contract.

CONTENT AND OPERATION

Overview

The bill makes changes to the law related to physical and occupational therapy copayments and Health Insurance Contract Law. The bill affects all types of health plan issuers, including health insuring corporations, sickness and accident insurers, multiple employer welfare arrangements, and public employee benefit plans.[1]

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[1] R.C. 1739.05, 1751.12(D)(4), and 3923.84(D).

Copayments for physical therapy

The bill prohibits health plan issuers from imposing copayment or coinsurance charges for physical or occupational therapy that is greater than that of a copayment or coinsurance for services provided by a primary care physician for an office visit.[2] A violation of this provision is an unfair and deceptive insurance practice.[3] Additionally, the bill requires health insuring corporations to clearly state the availability of physical and occupational therapy under its plans, including all related limitations, conditions, and exclusions.[4]

Health Insurance Contract Law

Intermediary organizations

The bill includes several provisions related to contracts between a health insurance carrier, public employee benefit plan, or health insuring corporation (a health plan issuer) and an intermediary organization. An intermediary organization is a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.[5]

The bill requires any contract between such a health plan issuer and an intermediary organization to require the intermediary organization to comply with the same standards, guidelines, medical policies, and terms of any contract the health plan issuer has with a provider. In other words, the bill prohibits health plan issuers from superseding an existing contract with a health service provider through the use of an intermediary organization. The bill also requires that contracts entered into between a health plan issuer and an intermediary organization require that any payments to a health service provider from an intermediary also include the name of the health plan issuer on whose behalf the payment was made. Finally, the bill requires each health plan issuer to annually file a statement with the Superintendent of Insurance disclosing every intermediary organization with which the health plan issuer contracts. A violation of these requirements is considered an unfair and deceptive insurance practice.

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[2] R.C. 1751.12(D)(4) and 3923.84(A).

[3] R.C. 1751.12(G) and 3923.84(C).

[4] R.C. 1739.05(B), 1751.12(D)(5), and 3923.84(B).

[5] R.C. 3963.01(J), by reference to R.C. 1751.01(P), not in the bill.

The bill authorizes the Superintendent, at any time, to request information concerning a health plan issuer's methodologies for reimbursing employers.[6]

Definition of contracting entity

The bill also expressly includes intermediary organizations within the definition of contracting entity in the Health Insurance Contract Law. Under current law, a contracting entity is any person that has a primary business purpose of contracting with participating providers for the delivery of health care services.[7] This expansion expressly subjects intermediary organizations to the Health Insurance Contract Law, including the following provisions:

- Assignment of right under health care contracts;[8]
- Specified duties regarding fees and fee schedules;[9]
- Standard credentialing forms;[10]
- Contracting entity prohibitions.[11]

Material amendment to a health care contract

The bill clarifies that if a participating provider properly objects to the material amendment of a health care contract, and there is no resolution, and neither party terminates the health care contract, the material amendment does not become part of the existing health care contract. A material amendment to a health care contract occurs only if the contracting entity provides to the participating provider the material amendment in writing and notice of the material amendment not later than 90 days prior to the effective date of the material amendment. If within 15 days after receiving the material amendment and notice, the participating provider objects in writing to the material amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the

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[6] R.C. 3963.031 and 1751.13(E).

[7] R.C. 3963.01(C).

[8] R.C. 3963.02, not in the bill.

[9] R.C. 3963.03, not in the bill.

[10] R.C. 3963.05 and 3963.06, not in the bill.

[11] R.C. 3963.11, not in the bill.

other party not later than 60 days prior to the effective date of the material amendment.[12]

Penalties for unfair and deceptive practices

As previously discussed, the bill makes certain insurance practices deceptive and unfair. The penalties for engaging in such actions are determined at the discretion of the Superintendent of Insurance and can include all of the following:

- Revocation of insurance license;
- Termination of the person responsible for the deceptive practice;
- Return of any payments received as a result of the practice;
- A fine of up to $100,000 for expenses incurred conducting the disciplinary hearing.[13]

HISTORY

ACTION	DATE
Introduced	09-27-11

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[12] R.C. 3963.04(A).

[13] R.C. 3901.22(D), not in the bill.