



Ohio Legislative Service Commission

Bill Analysis

Ashley Blackburn

H.B. 94

130th General Assembly
(As Introduced)

Reps. Gonzales, Becker, Brenner

BILL SUMMARY

- Requires health plan issuers to reimburse a local board of health for any services provided to an individual by the board that are covered by a plan issued to the individual, upon request by the board.

CONTENT AND OPERATION

Required reimbursement to boards of health for health care services

Under the bill, health care policies, contracts, agreements, and plans of health insuring corporations, sickness and accident insurers, public employee benefit plans, and multiple employer welfare arrangements are required to reimburse a local board of health for services provided under certain circumstances. If, under the bill, a local board of health provides a service to an individual who is a subscriber or individual covered by a policy or plan, and that service is covered by the health plan issuer, then the board is authorized to submit a claim to have the service reimbursed by the individual's health plan issuer. Under the bill, upon receipt of the claim the health plan issuer is required to reimburse the board of health for the service provided in accordance with the usual and customary rate schedule established by the policy or benefit plan. The health plan issuer is required to treat the board of health as within the issuer's network of service providers for the purposes of calculating the reimbursement.¹

¹ R.C. 1739.05, 1751.50, and 3923.84.

Under the bill, a "local board of health" means a board of health of a city or general health district or an authority having the duties of a board of health as authorized by the Health Districts Law.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 benefits 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,³ 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) 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.⁴

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.

HISTORY

ACTION	DATE
Introduced	03-06-13

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² R.C. 1751.50 and 3923.84 and, by reference, R.C. 3709.05.

³ R.C. Chapter 119.

⁴ R.C. 1739.05(B), 1751.50(B), and 3923.84(B).

