OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis

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H.B. 450

132nd General Assembly
(As Introduced)

Reps. Antani, Becker, Lang, Thompson

BILL SUMMARY

- Requires the Superintendent of Insurance to conduct an actuarial study on the cost of existing mandated health insurance benefits.
- Requires the Superintendent to compile a list of all such existing mandated benefits.
- Requires a copy of the list of mandated benefits to be included in each premium statement or invoice sent by an insurance carrier.
- Creates the Health Care Mandated Benefits Review Committee, which is to be responsible for reviewing existing mandated benefits and reporting on them.
- Prohibits the enactment of new mandated benefits unless certain criteria are met.
- Stipulates that, if a mandated benefit requires a benefit in addition to the essential health benefits specified under the Patient Protection and Affordable Care Act of 2010, then the state is to assume the cost of the mandated benefit.

CONTENT AND OPERATION

Summary

The bill imposes requirements in relation to health insurance mandated benefits already enacted in state law or considered by the Ohio General Assembly. Under the bill, "mandated benefit" refers to the imposition by the General Assembly of any of the following, in the context of a sickness and accident insurer, health insuring corporation, public employee benefit plan, a fully insured multiple employer welfare arrangement, or Medicaid plan:

- Any required coverage for a specified medical or health-related service, treatment, medication, or practice;
- Any required coverage for the services of specific health care providers;
- Any requirement that a health plan issuer offer coverage to specific individuals or groups;
- Any requirement that a health plan issuer offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees;
- Any required expansion of, or addition to, existing coverage;
- Any mandated reimbursement amount to specific health care providers.[1]

Note, however, that the term "mandated benefit" does not include any benefit required by federal law, such as federally imposed increases in Medicaid coverage requirements.[2]

Actuarial study

The bill amends a requirement that the Superintendent of Insurance conduct an actuarial study on the cost of mandated benefits enacted in state law. Under continuing law, the study requirement applies to mandated benefits imposed on all group and individual health benefit plans not subject to federal law. Also, the study is required to be provided to the Governor, the Speaker of the House, and the President of the Senate. Under the bill, the study is required to show the cost of such mandated benefits in both actual dollars and as a percentage of total health care premiums paid. Additionally, the bill requires the study information to be updated every five years, with the first such study being due April 6, 2019. The Department must also make a copy of the most recent study available on the Department's website.[3]

Summary report

The bill requires the Superintendent of Insurance to make a report summarizing all mandated benefits already existing in state law. This report is required to be provided to the Governor, the Speaker of the House, and the President of the Senate in

[1] R.C. 3901.88(A)(2) and, by reference, R.C. 103.144, not in the bill.

[2] R.C. 3901.88(A)(2).

[3] R.C. 3901.88.

an electronic format, with the first report being due one year after the bill's effective date and annually thereafter.[4]

Mandate list to accompany invoice

The bill requires an insurance carrier (see **COMMENT** 1) to include with every premium invoice or statement a notice listing all mandated benefits identified by the Superintendent in the summary report, discussed above under "**Summary report**," that are covered under the plan in question. The bill also requires the notice to include language substantially similar to the following:

> The cost of your health insurance premium may be higher due to mandated benefits that are required by the State of Ohio to be included as part of every health insurance plan offered in Ohio, regardless of whether plan participants need or use these benefits. The mandated benefits are listed in the enclosed document.
>
> If you are concerned about how these mandated benefits increase the cost of your health insurance premium, please contact your state legislator.[5]

Starting April 6, 2019, the notice is to include information about the cost of mandated benefits represented as a percentage of the total health care premiums paid by the insurance purchaser per the actuarial study discussed above under "**Actuarial Study**" and include language substantially similar to the following:

> An actuarial study conducted by the Ohio Department of Insurance estimated that your health insurance premiums might be lower by as much as the amount included in this notice were these benefits not required.[6]

Health Care Mandated Benefits Review Committee

The bill establishes the Health Care Mandated Benefits Review Committee to regularly review all existing mandated benefits. This review is to include all of the following:

- Examining the ongoing clinical efficacy of each mandated benefit;

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[4] R.C. 3901.881.

[5] R.C. 3901.882(A).

[6] R.C. 3901.882(B).

- Identifying any mandated benefit that is no longer clinically necessary or effective;

- Recommending to the General Assembly whether each mandated benefit should remain in statute as is or be repealed.

The Committee is required to present an electronic report of its findings to the Governor, the Speaker of the House, and the President of the Senate. The Committee's initial report is due no later than two years after the bill's effective date. Each subsequent report is due every seven years.[7]

Membership, first meeting, and quorum

The Committee is to consist of seven members, all of whom are to be experts in evidence-based medicine. The Committee members are to be appointed by the Department of Insurance, with the initial appointment being made no later than one year after the bill's effective date.[8] The bill requires the Committee to first meet not later than 30 days after the final appointment has been made to choose a chairperson and to establish a schedule for mandated benefits review. Four members of the Committee constitute a quorum to conduct committee business.[9]

The terms of the initial appointments are to be staggered as follows:

- One member is to have a term of one year;

- Two members are to have a term of two years;

- Two members are to have a term of three years;

- Two members are to have a term of four years.

Except for members appointed to fill a vacancy, any member of the Committee appointed after the initial appointment is to have a term of four years.[10] Any member of the board appointed to fill a vacancy will serve the remainder of the member's predecessor's term. Vacancies on the board are to be filled via appointment by the Department of Insurance.[11] Members may be reappointed.[12] Upon expiration of a

[7] R.C. 3901.884.

[8] R.C. 3901.883(A) and (B).

[9] R.C. 3901.883(F).

[10] R.C. 3901.883(B).

[11] R.C. 3901.883(D).

member's term, that member is to continue in office until the member's successor takes office or until a period of 60 days has passed, whichever occurs first.[13]

New mandated health benefits

- The bill prohibits the enactment of future mandated benefits unless all of the following conditions are met:

- During the calendar year preceding the mandated benefit's effective date, the consumer price index measure for medical care services is equal to or below the consumer price index measure for all items, as determined by the United States Bureau of Labor Statistics. In other words, the cost of health care services must have increased over the previous year in an amount lower than general inflation for that year.

- The Department of Insurance has completed the report discussed below under "**Report on new mandated benefits.**"

- At least five other states have enacted a mandated benefit that is substantially similar to the proposed benefit and it can be determined that the mandated benefit has not increased the cost of health insurance premiums in those states.

- The mandated benefit also applies, beginning on the effective date of the statute, to public employee benefit plans, Medicaid plans, and any other health plans funded by the State of Ohio.[14] (see **COMMENT** 2.)

Report on new mandated benefits

The bill requires the Department of Insurance to complete a report pertaining to each newly proposed mandated benefit and deliver the report to the chairperson and ranking minority member of any legislative committee considering the mandated benefit. This report is to contain both of the following:

- Alternative approaches to addressing the alleged lack of insurance coverage for the particular health care product or service in question;

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[12] R.C. 3901.883(C).

[13] R.C. 3901.883(E).

[14] R.C. 3901.886(A).

- Any gaps in insurance coverage that would still exist should the proposed mandated benefit be enacted.[15]

Cost of mandated benefits

The bill stipulates that, if a mandated benefit requires a benefit in addition to the essential health benefits specified under the federal Patient Protection and Affordable Care Act of 2010, then the state is to assume the cost of the mandated benefit as required under the federal act.[16]

Rules

The bill authorizes the Superintendent of Insurance to adopt rules as necessary to implement the bill's requirements.[17]

Definition of "health benefit plan"

Under the bill, "health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy that is less than 12 months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.[18]

COMMENT

1. The term "insurance carrier" is not defined in the bill, and therefore it is unclear as to exactly which entities this requirement would apply. It is possible that it would apply to only health insuring corporations and sickness and accident insurers, and not apply to multiple employee welfare arrangements and public employee benefit plans.

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[15] R.C. 3901.886(B).

[16] R.C. 3901.887, by reference to 42 U.S.C. 18031(d)(3).

[17] R.C. 3901.888.

[18] R.C. 3901.88(A)(2).

2. This requirement raises questions regarding delegation or transfer of legislative authority under Article II, Section 1 of the Ohio Constitution.[19]

HISTORY

ACTION	DATE
Introduced	12-12-17

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[19] *Belden v. Union Cent. Life Ins. Co.*, 143 Ohio St. 329 (1944); *Blue Cross of Northeast Ohio v. Ratchford*, 64 Ohio St.2d 256 (1980).