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S.B. 9
133rd General Assembly

Bill Analysis

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Version: As Reported by Senate Insurance and Financial Institutions

Primary Sponsor: Sen. Huffman

Nick Thomas, Research Associate

Summary

- Requires a health plan issuer, beginning in July 2020, to release the following to a requesting group policyholder: net claims data paid or incurred by month, monthly enrollment data, monthly prescription claims information, and, for paid claims over $30,000, the amount paid toward each claim and claimant health condition.
- Defines a group policyholder as being a policyholder for a health insurance policy covering 50 or more full-time employees who work an average of at least 30 hours per week during a calendar month, or at least 130 hours during the calendar month.
- Applies the disclosure requirement to claims data for the current, or immediately preceding, policy period, as requested by the policyholder.
- Provides protections from civil liability to the health plan issuer in relation to the disclosure of the claims data.
- Makes a series of violations of the bill's requirements that, taken together, constitute a pattern or practice, an unfair or deceptive practice in the business of insurance.

Detailed Analysis

Release of claims data

Duty to disclose

The bill requires a health plan issuer (see "**Scope**," below), upon request but not more than once per calendar year per group policyholder, to release to each group policyholder (including the authorized representative of a group policyholder) monthly claims data relating to the policy within 30 business days after receiving the request. The data released must include all of the following:

* This analysis was prepared before the report of the Senate Insurance and Financial Institutions Committee appeared in the Senate Journal.

1. The net claims paid or incurred by month;
2. If the group policyholder is an employer, the monthly enrollment data by employee only, employee and spouse, and employee and family. Otherwise, the monthly enrollment data must be provided and organized in a relevant manner.
3. Monthly prescription claims information; and
4. Paid claims over $30,000, including a claim identifier other than the name and date of the occurrence, the amount paid toward each claim, and claimant health condition or diagnosis.

The claims data must be for the current, or immediately preceding, policy period, as requested by the policyholder.[1]

Protections of the health plan issuer

A health plan issuer that discloses claims data under the bill may condition disclosure on an agreement that releases the health plan issuer from civil liability regarding the use of the data. Furthermore, the bill stipulates that a health plan issuer is also absolved of civil liability relating to subsequent use of the data. By authorizing disclosure of data, the bill does not authorize disclosure of the identity of a particular covered individual or any particular health insurance claim, condition, or diagnosis in violation of federal or state law.[2]

The bill entitles a group policyholder to receive protected information only after an authorized representative of the group policyholder certifies that (1) the health plan documents comply with federal laws and regulations relating to disclosures[3] and (2) the policyholder will safeguard and limit the disclosure of protected health information (individually identifiable health information). A group policyholder that fails to provide the appropriate certification is not entitled to receive protected health information described in (4) above, but may receive a report of claim information described in (1), (2), and (3), above.[4]

Enforcement

A health plan issuer that commits a series of violations of these requirements that, taken together, constitute a practice or pattern is deemed to have engaged in an unfair and deceptive act or practice in the business of insurance and is subject to sanctions under Ohio Insurance Law.[5]

Disclosure of other information

The bill specifies that it does not prohibit a health plan issuer from disclosing additional claims information beyond what the bill requires.[6]

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[1] R.C. 3901.89(A)(2) and (B).

[2] R.C. 3901.89(C), (D), and (E).

[3] See **COMMENT**, below.

[4] R.C. 3901.89(F) and (G) and 45 C.F.R. 160.103 and 164.504(f), not in the bill.

[5] R.C. 3901.89(H).

[6] R.C. 3901.89(I).

The bill exempts disclosures made in accordance with the bill to a group policyholder from the prohibition against an insurance institution, agent, or insurance support organization disclosing personal or privileged information.[7]

Scope

A "health plan issuer" under the bill is an entity subject to Ohio Insurance Laws or the Superintendent of Insurance's jurisdiction that contracts, or offers to contract, to provide, or pay for, health care services under a health benefit plan. In addition to a sickness and accident insurer, health insuring corporation, fraternal benefit society, self-funded multiple employer welfare arrangement, and nonfederal, government health plan, the bill applies to a third party administrator to the extent that the benefits that it administers are subject to Ohio Insurance Laws and Rules or the Superintendent's jurisdiction.[8]

Additionally, a "group policyholder" is a policyholder for a health insurance policy covering 50 or more full-time employees. A "full-time employee" is an employee working an average of at least 30 hours per week during a calendar month, or at least 130 hours during a calendar month.[9]

Effective date

The bill takes effect July 1, 2020.[10]

Comment

The bill raises questions with regard to its interaction with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA's privacy rule prohibits covered entities from disclosing protected health information. Generally speaking, HIPAA prohibits disclosures of protected health information to third parties unless those disclosures are made in relation to treatment, payment, or health care operations.[11] It is unclear whether the disclosures made to an employer required by the bill would fall under any of these categories. Furthermore, federal rules prescribe only two situations in which the disclosure of protected health information from a health plan issuer to a plan sponsor is explicitly authorized:

- To obtain premium bids from health plans for providing health insurance;
- To modify, amend, or terminate the group health plan.[12]

Note, however, that the HIPAA privacy rule does not apply to information that does not identify or provide a reasonable basis to identify an individual.[13] Accordingly, if a health plan

[7] R.C. 3904.13(O).

[8] R.C. 3901.89, by reference to R.C. 3922.01(P), not in the bill.

[9] R.C. 3901.89(A)(1) and (2).

[10] Section 3.

[11] 45 C.F.R. 164.502(a).

[12] 45 C.F.R. 164.504(f)(1)(ii).

[13] 45 C.F.R. 164.502(d)(2).

issuer could disclose information in a way that was sufficiently anonymous, it would likely not be in conflict with HIPAA.

History

Action	Date
Introduced	02-12-19
Reported, S. Insurance and Financial Institutions	---

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