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S.B. 116
133rd General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Sen. Maharath

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SUMMARY

- Requires health plan issuers to cover maternity services.

DETAILED ANALYSIS

Overview

The bill requires health plan issuers to cover maternity services.[1] Under the bill, maternity services include all of the following:

- Care during pregnancy;
- Care during labor;
- Birthing;
- Prenatal care;
- Postpartum care.[2]

The bill stipulates that its requirements are not to be construed as prohibiting cost-sharing requirements in relation to providing these benefits. "Cost sharing" is any cost to an individual covered under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by a health benefit plan.[3] The bill would apply to health insuring corporations, sickness and accident insurers, multiple employer welfare arrangements, and public employee benefit plans.[4]

[1] R.C. 3902.50(B).

[2] R.C. 3902.50(A)(3).

[3] R.C. 3902.50(A)(1) and (C).

[4] R.C. 3902.50(A)(2) and R.C. 3922.01, not in the bill.

Overlapping requirements

The coverage required under the bill appears to overlap existing law, as both Ohio Insurance Law and the federal Patient Protection and Affordable Care Act of 2010 (ACA) impose coverage requirements related to maternity care. Note, however, that the various laws apply to *different types of plans*, as follows:

- The ACA requirements apply to ALL individual and small group plans, including those offered by health insuring corporations;[5]
- As federal law takes precedent, current Ohio Insurance Law would then apply to only large group plans offered by health insuring corporations and sickness and accident insurers, as well as any public employee benefit plans and multiple employer welfare arrangements, that provide maternity benefits;[6]
- Similar to existing Ohio law, the bill would apply to large group plans offered by health insuring corporations and sickness and accident insurers, as well as any multiple employer welfare arrangements and public employee benefit plans, regardless of whether or not they provide maternity benefits.[7]

Note, however, that it is unclear how the bill's requirements would interact with the current law requirements imposed on health plan issuers.

Already required maternity coverage

Both current Ohio and federal law require specific maternity benefits. Note, however, that the specific Ohio requirements only apply to a health benefit plan if that plan provides maternity benefits of some sort; the federal requirements apply to *all* plans that are subject to the ACA's essential health benefits requirements.

Under current Ohio law, health plan issuers that provide maternity benefits are required to provide maternity inpatient care according to the following:

- A minimum of 48 hours following a normal vaginal delivery;
- A minimum of 96 hours following a cesarean delivery.

Inpatient care includes medical, educational, and any other services that are consistent with the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

The inpatient care requirements imposed by the ACA are essentially the same, but are restricted to those recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

[5] 42 United States Code (U.S.C.) 300gg-6.

[6] R.C. 1739.05, 1751.67, 3923.63, and 3923.64, not in the bill.

[7] R.C. 3902.50.

Under Ohio law, health plan issuers are also required to provide follow-up care directed by either a physician or an advanced practice, registered nurse. Services covered as follow-up care include all of the following:

- Physical assessment of the mother and newborn;
- Parent education;
- Assistance and training in breast or bottle feeding;
- Assessment of the home support system;
- Performance of any medically necessary and appropriate clinical tests;
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

The coverage applies to both services provided in the hospital and at home, though in-home services must be provided by a provider who is knowledgeable and experienced in maternity and newborn care. If a patient is discharged *prior to* the inpatient deadlines described above (48 hours or 96 hours, depending), then coverage is required for only 72 hours after discharge. If the patient receives *at least* the number of hours of inpatient care required above, then the coverage is to be in accordance with the recommendations of the discharging health care provider.

Outpatient services that are required to be covered under the ACA are largely the same, but the coverage window is limited to 72 hours, regardless of when the patient discharged.[8]

HISTORY

Action	Date
Introduced	03-22-19

S0116-I-133/ar

[8] R.C. 1739.05, 1751.67, 3923.63, and 3923.64, not in the bill; 42 U.S.C. 18022; and the Ohio Essential Health Benefits Benchmark Plan, https://www.cms.gov/cciio/resources/data-resources/ehb.html#Ohio, accessed September 24, 2019.