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Ohio Legislative Service Commission

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H.B. 198*

134th General Assembly

Bill Analysis

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Version: As Reported by House Health

Primary Sponsors: Reps. Russo and Manchester

Nick Thomas, Research Analyst

SUMMARY

- Requires health plan issuers to cover hearing aids and related services for persons 21 years of age and younger.
- Names the bill "Madeline's Law."

DETAILED ANALYSIS

The bill requires health benefit plans to provide coverage for the cost of both of the following:

- One hearing aid (including attachments, accessories, and parts other than batteries and cords) per hearing-impaired ear up to $2,500 every 48 months for a covered person 21 years old or younger; and
- All related services prescribed by an otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, licensed hearing aid dealer, or otolaryngologist.

A covered person may choose a hearing aid at any price, but the bill does not require the health benefit plan to cover any costs beyond $2,500 in any 48-month period per hearing aid. Moreover, if a covered person chooses a more expensive hearing aid, the health plan issuer is prohibited from imposing any financial or contractual penalty on the covered person or hearing aid provider.

* This analysis was prepared before the report of the House Health Committee appeared in the House Journal. Note that the legislative history may be incomplete.

The bill allows a health plan issuer to deny a claim for a hearing aid if, less than 48 months prior to the claim, the covered person received the coverage identified above from any other health benefit plan.

A health benefit plan is required to cover only hearing aids that are medically appropriate with regard to the covered person in question. Conversely, health benefit plans may not exclude coverage for any hearing aid that is medically appropriate with regard to the covered person in question. The State Speech and Hearing Professionals Board is required to adopt professional standards related to medical appropriateness in hearing aids and compliance with the bill's requirements.

Under the bill, "health plan issuer" includes sickness and accident insurers, health insuring corporations, fraternal benefit societies, self-funded multiple employer welfare arrangements, nonfederal government health plans, and under certain circumstances third party administrators.[1]

The bill might be considered a mandated health benefit. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal "Employee Retirement Income Security Act of 1974" (ERISA),[2] and to employee benefit plans established or modified by the state or any of its political subdivisions. ERISA appears to preempt any state regulation of such plans.[3] The bill contains provisions that exempt its requirements from this restriction.[4]

HISTORY

Action	Date
Introduced	03-10-21
Reported, H. Health	---

ANHB0198RH-134/ar

[1] R.C. 3902.50 and 3902.62, conforming amendments in R.C. 3902.60 and 3902.70, and R.C. 3922.01, not in the bill.

[2] 29 U.S.C. 1001, as amended.

[3] 29 U.S.C. 1144.

[4] R.C. 3902.62(B).