Ohio Legislative Service Commission

Bill Analysis

Nick Thomas

Am. S.B. 227*

132nd General Assembly
(As Reported by S. Insurance and Financial Institutions)

Sens. Huffman, Coley, LaRose, Terhar, Beagle

BILL SUMMARY

- Requires a health plan issuer, beginning in 2019, to release the following to a requesting group policyholder: net claims data paid by month, monthly enrollment, the claims reserve amount, and, for claims over $10,000, the amount paid toward each claim, which claims are unpaid or outstanding, and claimant health condition.
- Defines a group policyholder as being a policyholder for a health insurance policy covering 50 or more full-time employees.
- Defines a full-time employee as an employee working 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 failure to comply with the bill an unfair or deceptive practice in the business of insurance.

* This analysis was prepared before the report of the Senate Insurance and Financial Institutions Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

CONTENT AND OPERATION

Release of claims data

Duty to disclose

The bill requires a health plan issuer (see "**Scope**," below), upon request, to release to each group policyholder (including the authorized representative of a group policyholder) claims data relating to the policy within 14 business days after receiving the request. The data released must include all of the following:

(1) The net claims paid by month;

(2) If the group policyholder is an employer, the monthly enrollment by employee only, employee and spouse, and employee and family. Otherwise, the monthly enrollment must be provided and organized in a relevant manner.

(3) The amount of any claims reserve established by the health plan issuer against future claims under the policy;

(4) Claims over $10,000, including a claim identifier other than the name and date of the occurrence, the amount paid toward each claim, which claims are unpaid or outstanding, and claimant health condition or diagnosis;

(5) A list of all potential catastrophic diagnoses and prognoses involving covered persons.

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, diagnosis, or prognosis in violation of federal or state law.[2]

---

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

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

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) and (5) above, but may receive a report of claim information described in (1), (2), and (3), above.[4]

Enforcement

A health plan issuer that fails to comply with these requirements 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 personal or privileged insurance information

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.[6]

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.[7]

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

---

[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. 3904.13(O).

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

working an average of at least 30 hours per week during a calendar month, or at least 130 hours during a calendar month.[8]

Effective date

The bill takes effect January 1, 2019.[9]

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.[10] 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.[11]

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.[12] Accordingly, if a health plan issuer could disclose information in a way that was sufficiently anonymous, it would likely not be in conflict with HIPAA.

HISTORY

ACTION	DATE
Introduced	11-02-17
Reported, S. Insurance and Financial Institutions	---

S0227-RS-132.docx/ec

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

[9] Section 3.

[10] 45 C.F.R. 164.502(a).

[11] 45 C.F.R. 164.504(f)(1)(ii).

[12] 45 C.F.R. 164.502(d)(2).