OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis

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H.B. 367*

132nd General Assembly
(As Reported by H. Health)

Reps. DeVitis, Duffey, Hood, Johnson, Butler, Becker, Antani, Celebrezze, Retherford, Scherer, Blessing, Lipps

BILL SUMMARY

- Prohibits a contracting entity from requiring a dental provider to provide services to plan enrollees at a fee set by or subject to approval by the contracting entity unless the services are covered dental services.
- Makes setting or requiring the insurer's approval of fees for dental services that are not covered dental services an unfair and deceptive act in the business of insurance.
- Makes the offering of a health benefit plan that sets fees for dental services that are not covered dental services an unfair and deceptive act in the business of insurance.

CONTENT AND OPERATION

Contracting for rates on uncovered services

The bill prohibits a contracting entity from requiring, in a health care contract, a dental provider to provide dental services at a fee set by the contracting entity (any person that has a primary business purpose of contracting with participating providers for the delivery of health care services[1]) or subject to approval by the contracting entity unless the services in question are "covered dental services."[2] Covered dental services are those services for which a reimbursement is available under an enrollee's health

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

[1] R.C. 3963.01(C).

[2] R.C. 3963.02(E)(1) and a conforming change in R.C. 1753.09(F)(3).

benefit plan contract or would be available but for contractual limitations such as deductibles, copayments, coinsurance, waiting periods, frequency limitations, alternative benefit payments, or annual or lifetime limits.[3]

The above prohibition would become part of Ohio's Health Care Contract Law.[4] Continuing law authorizes the Superintendent of Insurance to conduct a market investigation of any person regulated by the Department of Insurance under Ohio's Insurance Law or Ohio's Corporation and Partnership Law to determine whether any violation of the Health Care Contract Law has occurred. When conducting such an examination, the Superintendent may assess the costs of the examination against the person examined. The Superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of the Health Care Contract Law. In addition, a series of violations of the Health Care Contract Law by any person regulated by the Department of Insurance that, taken together, constitute a pattern or practice of violating that Law may constitute an unfair and deceptive insurance practice.[5]

The bill also makes it an unfair or deceptive practice in the business of insurance to set or require the insurer's approval of fees for dental services that are not covered dental services or to make available a health benefit plan that sets fees for dental services that are not covered dental services.[6]

Under continuing law, a person who is found to have committed an unfair or deceptive practice in the business of insurance is subject to any or all of the following sanctions:

- Suspension or revocation of the person's license to engage in the business of insurance;
- Prohibition on an insurance company or insurance agency employing the person or permitting the person to serve the company or agency in any capacity for a period of time;
- Return of any payments received by the person as a result of the violation;

[3] R.C. 3963.01(D) and a conforming change in R.C. 3963.03(B).

[4] R.C. Chapter 3963.

[5] R.C. 3963.09, not in the bill.

[6] R.C. 3901.21(BB)(1).

- Fees for attorneys and other costs of any investigation into the violations committed by the person.[7]

ERISA

The bill's prohibitions do not apply in cases where they are in conflict with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, as amended.[8]

General Assembly's intent and findings

The bill provides that the provisions of the bill seek to prevent dental insurers, dental benefit plans, and other contracting entities from establishing fee limitations on services that are not covered dental services for enrollees under a dental insurance plan.

Additionally, the bill provides that strategies by dental insurers, dental benefit plans, or other contracting entities to adopt or impose a deductible, copayment, coinsurance, or any other requirement in such a way as to provide only nominal reimbursement for services as a method to avoid the impact of the bill is contrary to the spirit and intent of the General Assembly.[9]

HISTORY

ACTION	DATE
Introduced	10-02-17
Reported, H. Health	---

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[7] R.C. 3901.22, not in the bill.

[8] R.C. 3901.21(BB)(2) and 3963.02(E)(2).

[9] Section 3 of the bill.