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Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Crossman and Lightbody

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SUMMARY

- Repeals outright suspended provisions that allowed health insurers to pass on the cost of reinsurance to certain high risk individuals.
- Codifies in state law the federal Patient Protection and Affordable Care Act's (ACA's) limitations on premium charges.
- Codifies in state law the ACA's ban of annual and lifetime limits.
- Codifies in state law the ACA's ban on preexisting condition exclusions.
- Codifies in state law the ACA's provisions requiring health plans to offer certain essential health benefits.
- Codifies in state law the ACA's cost sharing limitations.
- Codifies in state law the ACA's requirement that a health plan provide benefits that are actuarially equivalent to at least 60% of the full actuarial value of the benefits provided.

DETAILED ANALYSIS

High risk pool repeal

Prior to the passage of the federal Patient Protection and Affordable Care Act (ACA) in 2010, Ohio had several provisions relating to the use of so-called "high risk pools" by certain health insurers (specifically, health insuring corporations, sickness and accident insurers, and multiple employer welfare arrangements).[1] In short, insurers that offered individual (nongroup) plans had to accept most individuals who applied for coverage during an open enrollment period. These insurers could then purchase reinsurance for individuals with preexisting

[1] R.C. 3924.01.

conditions (the "high risk" individuals). The cost of this reinsurance could then be passed on to these individuals in the form of higher premiums (up to five times higher). Thus, "high risk pool" refers to the set of individuals whose plans were reinsured and who paid higher premiums to offset the cost of reinsurance. These provisions are currently suspended,[2] as the ACA requires coverage of all individuals who apply for coverage and bans preexisting condition exclusions. The bill repeals outright these suspended provisions.[3]

Limitations on premium charges

The bill codifies the ACA's limitations on premium charges. In particular, it provides that the premium rate for a health benefit plan (any plan of comprehensive health coverage the state may regulate, including any plan offered by a health insuring corporation, sickness and accident insurer, public employee benefit plan, multiple employer welfare arrangement, or fraternal benefit society, and not including a short-term limited duration plan or other limited benefit plan) may vary only with respect to the following factors:

- Whether the health benefit plan covers an individual or family;
- The rating area (an area within the state defined by the Superintendent of Insurance for purposes of setting rates);
- Age, except that such rate may not vary by more than three to one for adults; and
- Tobacco use, except that such rate cannot vary by more than one and one-half to one.[4]

With respect to family plans, the rating variations above must be applied based on the portion of the premium that is attributable to each family member. For example, if one family member smokes but the others do not, any increase based on tobacco use may only take into account that particular person's tobacco use and cannot increase the premium as if all family members smoked.[5]

The bill further requires the Superintendent of Insurance to adopt rules establishing rating areas within the state and defining permissible age bands for purposes of the third bullet point above.[6]

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[2] Section 3 of S.B. 9 of the 130th General Assembly, as amended by Section 610.53 of H.B. 49 of the 132nd General Assembly.

[3] Section 3 of the bill, repealing R.C. 1751.15, 3923.58, 3923.581, 3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 3924.111, 3924.12, 3924.13, and 3924.14; conforming changes in R.C. 1731.03, 1731.05, 1731.09, 1739.05, 1751.16, 1751.18, 3923.122, 3923.57, 3924.01, 3924.02, 3924.06, and 3924.73.

[4] R.C. 3902.40(B) and (C) and 3902.41(A).

[5] R.C. 3902.41(B).

[6] R.C. 3902.41(C).

Application

These provisions apply to individual and small group plans.[7]

Annual and lifetime limits

The bill codifies the ACA's ban on the use of annual or lifetime limits on the dollar value of essential health benefits (see "**Essential health benefits**" below).[8]

Application

These provisions apply to individual and small group plans.[9]

Preexisting conditions

The bill also codifies the ACA's ban on the use of preexisting condition exclusions. A preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment in the plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. "Condition" does not include genetic information in the absence of a diagnosis of the condition related to such information.[10] Specifically, the bill requires a health benefit plan to accept any individual or employer that applies for coverage, regardless of whether any individual or employee has a preexisting condition, subject to an open enrollment period (a period during which all employees of an employer may opt into, opt out of, or modify coverage) or a special enrollment period (a period outside of open enrollment during which a person may opt into, opt out of, or modify coverage because of a qualifying event). It also prohibits a health plan issuer (an entity offering a health benefit plan) from imposing any preexisting condition exclusion on any person.[11]

Under the bill, the Superintendent must adopt rules to establish a statewide open enrollment period for individual plans. Furthermore, each health plan issuer must provide special enrollment periods for individuals who would otherwise lose coverage as a result of any of the following:

- The person had other coverage when first offered new coverage (e.g., a person was covered under a spouse's coverage and therefore declined coverage offered by the person's employer) and all of the following applied:

[7] R.C. 3902.41(A).

[8] R.C. 3902.41(D).

[9] R.C. 3902.41(D) and 3902.43(E).

[10] R.C. 3902.40(E).

[11] R.C. 3902.40(B) and 3902.42(A) and (B); conforming changes in R.C. 1731.04, 1751.06, 1751.58, 3901.381, 3922.01, 3923.57, 3923.571, 3924.01, 3924.02, 3924.03, 3924.033, and 3924.51.

- The employee stated in writing at the time coverage was offered that existing coverage was the reason for declining coverage, but only if the employer required such a written statement;
- The person's existing coverage has since ended for either of the following reasons:
  - It was under a COBRA continuation provision[12] that has been exhausted; or
  - It was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
- Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion or termination of the previous coverage.

- The employee has died.
- The employee was terminated or had hours reduced.
- The employee and the employee's spouse divorced or legally separated.
- The employee became entitled to Medicare.
- A dependent child ceased to be a dependent child.
- The employee was retired and the employer declared bankruptcy.[13]

Application

These provisions apply to all health benefit plans.[14]

Essential health benefits

The bill codifies into state law the ACA's essential health benefits requirements. It requires health plan issuers to offer essential health benefits and requires the Superintendent to define what those essential health benefits are. Any definition must include at least the following general categories and the items and services covered within the categories:

- Ambulatory patient services;
- Emergency services;

[12] The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. See 29 United States Code (U.S.C.) 1161 *et seq.* and https://www.dol.gov/general/topic/health-plans/cobra.

[13] R.C. 3902.42(C); 26 United States Code (U.S.C.) 9801(f) and 29 U.S.C. 1163, not in the bill.

[14] R.C. 3902.42(A).

- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care.[15]

The Superintendent must ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan. To do so, the Superintendent must conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multi-employer plans. In defining and revising the benefits, the Superintendent must report and certify to the General Assembly that such essential health benefits meet this typicality requirement.[16]

In defining the essential health benefits, the Superintendent must do all of the following:

- Ensure that the essential health benefits reflect an appropriate balance among the categories, so that benefits are not unduly weighted toward any category;
- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
- Ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;
- Provide that a qualified health benefit plan shall not be treated as providing coverage for the essential health benefits unless the plan does both of the following:
  - Provides that coverage for emergency services will be provided with no prior authorization requirement or other coverage limitation on out-of-network providers

[15] R.C. 3902.43(A), (B)(1), (B)(5), and (D)(1)(b); conforming change in R.C. 1751.01.

[16] R.C. 3902.43(B)(2).

that is more restrictive than those requirements or limitations on in-network providers. "Emergency services" means (1) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition, and (2) such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

- Provides that if emergency services are provided out-of-network, the cost-sharing requirement is the same requirement that would apply if such services were provided in-network.

- Periodically review the essential health benefits and provide a report to the General Assembly and the public that contains all of the following:
  - An assessment of whether covered persons are facing any difficulty accessing needed services for reasons of coverage or cost;
  - An assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;
  - Information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;
  - An assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet the typicality requirements described above.
- Periodically update the essential health benefits to address any gaps in access to coverage or changes in the evidence base the Superintendent identifies in the review conducted under the above bullet point.[17]

Nothing in the bill is to be construed to prohibit a health benefit plan from providing benefits in excess of the essential health benefits.[18]

Applicability

These provisions apply to individual and small group plans.[19]

Preventive services

The bill requires a health benefit plan to cover and not impose any cost-sharing requirements for the following:

[17] R.C. 3902.43(B)(3); R.C. 3923.65, not in the bill.

[18] R.C. 3902.43(B)(4).

[19] R.C. 3902.43(E).

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the advisory committee on immunization practices of the U.S. Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration;
- With respect to women, such additional preventive care and screenings not described in the first bullet point above as provided for in comprehensive guidelines supported by the U.S. Health Resources and Services Administration.[20]

Applicability

These provisions apply to all health benefit plans.[21]

Cost sharing

Under the bill, a health plan issuer cannot require cost sharing (the cost to a covered person under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement) in an amount greater than $8,150 for self-only coverage and $16,300 for other than self-only coverage for plan years beginning in 2021. For plan years beginning after 2021, the cost-sharing limit is as follows:

- For self-only coverage, equal to $8,150 plus the product of that amount and the premium adjustment percentage for that calendar year. The premium adjustment percentage for a particular year is the percentage by which the average per capita premium for health benefit plans in Ohio for the preceding calendar year, as estimated by the Superintendent not later than the first day of October of such preceding calendar year, exceeds the average per capita premium for 2019.
- For other than self-only coverage, twice the amount for self-only coverage. If the amount of any increase in self-only coverage is not a multiple of $50, the increase is rounded to the next lowest multiple of $50.[22]

Applicability

These provisions apply to individual and small group plans.[23]

[20] R.C. 3902.44(A).

[21] R.C. 3902.44(A).

[22] R.C. 3902.40(A) and 3902.43(C).

[23] R.C. 3902.43(E).

Level of coverage

Except as provided in the below paragraph, the bill requires a health benefit plan to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to at least 60% of the full actuarial value of the benefits provided under the plan. Under rules issued by the Superintendent, a plan's level of coverage must be determined on the basis that the essential health benefits must be provided to a standard population, without regard to the population the plan may actually provide benefits to.[24]

A health benefit plan that does not provide the level of coverage described above nonetheless meets the bill's requirements for a plan year if both of the following apply:

- An individual is only eligible to enroll in the health benefit plan if the individual meets either of the following conditions:
  - The individual has not attained the age of 30 before the beginning of the plan year; or
  - The individual meets a hardship exemption as determined by the Superintendent.
- The health benefit plan provides both of the following:
  - Except as provided in the below bullet point, all essential health benefits, except that the health benefit plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation described in "**Cost sharing**," above. The plan must, however, provide the services described in "**Preventive services**," above, with no cost-sharing requirements.
  - Coverage for at least three primary care visits.[25]

Such a health benefit plan is known as a "catastrophic plan." If a health plan issuer offers a catastrophic plan, it must only do so in the individual market.[26]

Applicability

These provisions apply to individual and small group plans.[27]

Rules

The bill requires the Superintendent of Insurance to adopt rules implementing its provisions.[28]

[24] R.C. 3902.43(D)(1).

[25] R.C. 3902.43(D)(2).

[26] R.C. 3902.43(D)(3), conforming changes in R.C. 1751.12, 1751.69, and 3923.85.

[27] R.C. 3902.43(E).

[28] R.C. 3902.44(B).

Exemption from review by the Superintendent of Insurance

The bill's enactment of the essential health benefits provisions 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),[29] 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.[30] The bill contains provisions that exempt its requirements from this restriction.[31]

HISTORY

Action	Date
Introduced	02-16-21

H0125-I-134/ks

[29] 29 U.S.C. 1001, not in the bill.

[30] 29 U.S.C. 1144, not in the bill.

[31] R.C. 3902.43(F).