Ohio Legislative Service Commission

Bill Analysis

Lisa Musielewicz

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131st General Assembly
(As Reported by S. Health and Human Services)

Reps. Schuring, Bishoff, Brown, T. Johnson, Anielski, Antonio, Arndt, Baker, Barnes, Boyd, Craig, Curtin, Derickson, Dovilla, Grossman, Hambley, Lepore-Hagan, McClain, M. O'Brien, Patterson, Ramos, Rezabek, Rogers, Scherer, Sears, Slesnick, Sweeney, Young

BILL SUMMARY

PALLIATIVE CARE FACILITIES

- Requires the Ohio Department of Health (ODH) to regulate palliative care facilities through a licensing process that is similar to ODH's licensure of hospice care programs and pediatric respite care programs.
- Provides for the regulation of palliative care facilities by creating licensing procedures, requiring inspections, authorizing disciplinary actions, and requiring the Director of Health to adopt necessary rules.
- Specifies that the provision of palliative care is not limited to palliative care facilities, hospice care programs, or pediatric respite care programs.
- Permits a licensed hospice care program that operates an inpatient facility or unit to provide palliative care to any patient, rather than only hospice patients.

HOSPITAL AFTER-CARE AND DISCHARGE PLANNING

- Requires hospitals to give a patient or the patient's guardian the option of designating a lay caregiver for the patient (a person who provides after-care to the patient in the patient's residence after discharge).

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

- Specifies a hospital's duties once a lay caregiver designation has been made, including the duty to create a discharge plan and review the plan with the patient's lay caregiver (in addition to the patient or guardian) if determined appropriate by the discharging health care professional.

- Requires a discharge plan to include a live demonstration of each task to be performed under the plan if the discharging health care professional determines a live demonstration would be appropriate.

- Specifies how a lay caregiver designation may be revoked.

- Grants a discharging health care professional immunity from criminal prosecution, civil liability, and professional disciplinary action for an event or occurrence that allegedly arises out of the professional's determination that a patient's lay caregiver should or should not participate in the review of the patient's discharge plan.

- Specifies that it is the General Assembly's intent that the bill not be construed to create a right of action against a hospital or a hospital employee, agent, or contractor, among other statements of statutory intent.

- Authorizes the Ohio Department of Health to adopt rules as necessary to implement the bill's provisions.

MEMORY CARE UNITS

- Requires the Director of Aging and the Director of Health to jointly develop recommendations regarding the establishment of standards and procedures for the operation of memory care units, as well as quality-of-care metrics for such units.

AUTISM COVERAGE

- Requires health plan issuers to provide coverage for autism spectrum disorder.

- Prescribes minimum coverage requirements for autism spectrum disorder.

- Allows a health plan issuer to review an autism spectrum disorder treatment plan on an annual basis.

- Allows a health plan issuer to review an autism spectrum disorder treatment plan more than once a year if the additional reviews are agreed to by the overseeing physician.

CRIMINAL PENALTY – ASSISTING SUICIDE

- Generally prohibits a person from knowingly causing another to commit or attempt to commit suicide by either providing the physical means to do so or participating in a physical act by which the person commits or attempts to commit suicide.

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CONTENT AND OPERATION

PALLIATIVE CARE FACILITIES

Regulation and licensure

The bill requires the Ohio Department of Health (ODH) to regulate palliative care facilities through a licensing process that is similar to ODH's licensure of hospice care programs and pediatric respite care programs.[1]

Definitions

As defined by the bill, "palliative care" means treatment for a patient with a serious, chronic, or life-threatening illness directed at controlling pain, relieving other symptoms, and enhancing the quality of life of the patient and the patient's family, particularly with psychosocial support and medical decision guidance, rather than treatment for the purpose of cure.[2]

The bill defines a "palliative care facility" as a facility operated by a person or public agency that provides inpatient palliative care on a continuous basis, 24 hours a day and seven days a week, the medical components of which are under the direction of a physician.[3] The bill also defines a "palliative care patient" as a patient who has voluntarily requested and is receiving care from a person or public agency licensed to operate a palliative care facility.[4] The bill specifies that a "hospice care program" or "pediatric respite care program" does not include a palliative care facility. As a result, a palliative care facility is not subject to the other programs' licensing requirements.[5] The bill also states that it should not be interpreted to mean that palliative care can be provided only in a palliative care facility or as a component of a hospice care program or pediatric respite care program.[6]

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[1] R.C. 3712.032.

[2] R.C. 3712.01(E).

[3] R.C. 3712.01(M).

[4] R.C. 3712.01(N).

[5] R.C. 3712.01(A) and (J), 3712.03, not in the bill, 3712.031, not in the bill, and 3712.032.

[6] R.C. 3712.01(E).

Prohibitions against unlicensed activities

The bill prohibits a person or public agency from doing any of the following without a license:[7]

--Holding itself out as operating a palliative care facility;

--Operating a palliative care facility.

ODH must petition the court of common pleas of the county in which the prohibited activity is taking place for an order enjoining that person or public agency from conducting those activities without a license. Any person or public agency may request ODH to petition the court, and ODH must do so if it determines that the person or public agency named in the request is violating one or more of the prohibitions described above. The bill specifies that the court has jurisdiction to grant injunctive relief upon a showing that the person or public agency named in the petition is conducting those activities without a license.[8]

Exemptions

The bill provides that the prohibitions against unlicensed activities described above do not apply to any of the following:[9]

(1) A member of an interdisciplinary team or an employee of a licensed palliative care facility;

(2) A hospital;

(3) A nursing home or residential care facility;

(4) A home health agency;

(5) A regional, state, or national nonprofit organization whose members are operators of palliative care facilities, individuals interested in palliative care facilities, or both, as long as the organization does not provide or represent that it operates a palliative care facility;

(6) A person or government entity certified by the Ohio Department of Developmental Disabilities (ODODD) as a supported living provider;

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[7] R.C. 3712.052(A).

[8] R.C. 3712.052(C).

[9] R.C. 3712.052(A) and (B).

(7) A residential facility licensed by ODODD;

(8) A respite care home certified by a county board of developmental disabilities;

(9) A person providing respite care under a family support services program established by a county board of developmental disabilities;

(10) A person or government entity providing respite care under an ODODD-administered Medicaid waiver;

(11) A hospice care program licensed by ODH;

(12) A terminal care facility for the homeless that has entered into an agreement with a licensed hospice care program for the provision of hospice care services at the facility;

(13) A pediatric respite care program licensed by ODH.

Licensure process

Under the bill, every person or public agency that proposes to operate a palliative care facility must apply to ODH for a license. An applicant must provide required information on a form prescribed and provided by ODH and pay the required license fee established by rules to be adopted by the Director of Health.[10] The fee cannot exceed $600; however, with Controlling Board approval, the Director of Health may establish a fee that is up to 50% higher.[11]

ODH must grant a license to the applicant if the applicant is in compliance with the statutes and rules governing palliative care facilities. A license is valid for three years.[12]

License renewal

A licensed palliative care facility may renew its license by applying for renewal in the same manner as applying for initial licensure and providing a license renewal fee established in rules to be adopted by the Director of Health.[13] The renewal fee cannot

[10] R.C. 3712.042.

[11] R.C. 3712.032(A)(2) and (C).

[12] R.C. 3712.042(A) and (B).

[13] R.C. 3712.042(B).

exceed $600; however, with Controlling Board approval, the Director may establish a fee that is up to 50% higher.[14]

An application for renewal must be made at least 90 days before the license expires. ODH must renew the license if the applicant is in compliance with the statutes and rules governing palliative care facilities.[15]

Inspections

ODH is required to make inspections as necessary, including those required by rules adopted under the bill, to determine whether palliative care facilities and services meet the requirements of the bill and the rules to be adopted under it.[16] The rules must require a palliative care facility to be inspected as a condition of initial licensure and not less than every three years thereafter while the license is maintained (see "**Rulemaking**," below).[17] An inspection fee must be established by the Director of Health in rules. The fee cannot exceed $1,750; however, with Controlling Board approval, the Director may establish a fee that is up to 50% higher.[18]

Disciplinary actions

ODH may suspend or revoke a license of a palliative care facility if the license holder made any material misrepresentation in the license application or no longer meets the requirements of the bill or the rules to be adopted under it. ODH must comply with the Administrative Procedure Act (R.C. Chapter 119.) when taking disciplinary actions.[19]

Rulemaking

Under the bill, the Director of Health must adopt, and may amend and rescind, rules in accordance with the Administrative Procedure Act that do all of the following:[20]

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[14] R.C. 3712.032(A)(2) and (C).

[15] R.C. 3712.042(B).

[16] R.C. 3712.032(D)(2).

[17] R.C. 3712.032(B)(1).

[18] R.C. 3712.032(A)(3).

[19] R.C. 3712.032(D)(1) and 3712.042(C).

[20] R.C. 3712.032(A) and R.C. 3712.09(F).

(1) Provide for the licensing of persons or public agencies operating palliative care facilities and the suspension and revocation of those licenses;

(2) Establish a license fee, license renewal fee, and inspection fee in accordance with the maximum amounts described above;

(3) Establish requirements for palliative care facilities and services;

(4) Provide for the granting of licenses to persons and public agencies that are accredited or certified to operate palliative care facilities by an entity whose standards for accreditation or certification equal or exceed those provided for by the bill and the rules to be adopted under it;

(5) Establish guidelines for quality assessment and performance improvement programs administered by palliative care facilities;

(6) Establish interpretive guidelines for the rules described above;

(7) Implement criminal background check requirements for applicants for employment with a palliative care facility who will be providing direct care to patients, including the circumstances under which a facility may employ a person who has been convicted of or pleaded guilty to specified offenses (such as certain sex and drug offenses) but meets personal character standards set by the Director.

The rules described in (1), above, must require a palliative care facility to be inspected as a condition of initial licensure and not less than every three years thereafter while the license is maintained.[21] The rules described in (3), above must:[22]

--Establish minimum standards governing a facility's physical layout and equipment, patient assessments, and patient care planning;

--Specify the number of qualified staff, including physicians, registered nurses, social workers, and spiritual or other counselors, that must be on duty 24 hours a day and seven days a week. The number of staff specified must be based on the number of patients the facility is able to admit and patient acuity levels;

--Specify that the medical components of the provision of palliative care must be under the direction of a physician; and

[21] R.C. 3712.032(B)(1) and (D)(2).

[22] R.C. 3712.032(B)(2).

--Specify that a palliative care facility must provide all of the following to meet the physical, psychological, social, spiritual, and other needs of a palliative care patient:

- Nursing care by or under the supervision of a registered nurse;
- Medical supplies, appliances, and drugs;
- Coordinated treatment planning that includes a central clinical record for each patient, a plan of care for each patient, and a procedure that addresses participation in decision-making by the patient and the patient's family; and
- Psychosocial support services.

Hospice care program law extended to palliative care facilities

The bill otherwise provides for palliative care facilities to be subject to the same requirements as hospice care and pediatric respite care programs. The issues addressed in the laws made applicable to palliative care facilities include the following:

--Required criminal records checks for applicants for employment with a palliative care facility who will be providing direct care to patients;[23]

--Permission to request criminal records checks for applicants for employment with a palliative care facility who will not be providing direct care to patients;[24]

--Requirements and responsibilities related to a patient's durable power of attorney for health care;[25]

--Requirements and responsibilities related to a patient's do-not-resuscitate order;[26]

--Provisions holding a palliative care facility liable for a physician's failure to obtain informed consent before a medical procedure only if the physician is employed by the facility;[27]

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[23] R.C. 3712.09.

[24] R.C. 109.57.

[25] R.C. 1337.11.

[26] R.C. 2133.01.

[27] R.C. 2317.54.

--Prohibitions related to assisted suicide.[28]

The bill also makes a number of changes to conform the licensing system of palliative care facilities to the licensing system of hospice care and pediatric respite care programs.[29]

Hospice care program law extended to health care professionals

In addition to extending hospice care and pediatric respite care requirements to palliative care facilities, the bill extends certain laws governing how licensed health professionals care for hospice patients to those professionals when providing care to palliative care patients. The issues include the following:[30]

--Provisions authorizing a nurse or physician assistant to determine and pronounce an individual's death;

--Provisions authorizing a clinical nurse specialist, certified nurse-midwife, certified nurse practitioner, or physician assistant to issue to a patient a prescription for a schedule II controlled substance;

--Provisions related to a review of patient information in the drug database established and maintained by the State Board of Pharmacy (OARRS);

--Provisions related to the delivery of non-self-injectable cancer drugs by a pharmacist or pharmacy intern;

--Requirements governing notice to patients of the termination of a physician's employment.

Provision of palliative care by inpatient hospice facilities and units

The bill permits a licensed hospice care program that operates an inpatient facility or unit to provide palliative care to any patient, notwithstanding any provision of Ohio law governing hospice care programs that limits such programs to providing services to hospice patients.[31] Under existing law not modified by the bill, a "hospice patient" is a patient, other than a pediatric respite care patient, who has been diagnosed as terminally ill, has an anticipated life expectancy of six months or less, and has

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[28] R.C. 3795.01.

[29] R.C. 140.01, 3701.881, 3721.01, 3963.01, 4719.01, 4752.02, and 5119.34.

[30] R.C. 4723.36, 4723.481, 4723.487, 4729.43, 4730.202, 4730.411, 4730.53, 4731.055, and 4731.228.

[31] R.C. 3712.063.

voluntarily requested and is receiving care from a licensed hospice care program.[32] Accordingly, under the bill, a patient who does not meet the criteria to be a hospice patient may receive palliative care from a hospice care program. The bill does not, however, affect Medicaid or Medicare payments for palliative care provided to hospice patients. Medicaid and Medicare will pay for hospice services (including palliative care provided to a hospice patient[33]) only if an individual elects hospice care in a written statement.[34]

HOSPITAL AFTER-CARE AND DISCHARGE PLANNING

Lay caregiver designation for hospital inpatients

Offer to patient or patient's guardian

The bill requires a hospital to offer a patient who is at least 55 years of age, or the patient's guardian, an opportunity to designate a lay caregiver for the patient. If the patient is not unconscious or otherwise incapacitated at the time of admission, the offer must be made after the patient's admission. If the patient is unconscious or otherwise incapacitated at the time of admission, the offer must be made after the patient regains consciousness or capacity and before the patient's discharge.[35]

The bill defines a "lay caregiver" as an adult designated in accordance with the bill to provide after-care to a patient.[36] "After-care" means assistance provided by a lay caregiver to a patient in the patient's residence after the patient's discharge from a hospital and includes only the caregiving needs of the patient at the time of discharge.[37] A patient's residence may be either the dwelling that a patient or the patient's guardian considers to be the patient's home or the dwelling of a relative or other individual who has agreed to temporarily house the patient following discharge and who has

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[32] R.C. 3712.01(B).

[33] Under existing ODH rules, short-term inpatient care, including palliative care, may be provided to hospice patients. *See* O.A.C. 3701-19-01(I)(7).

[34] O.A.C. 5160-56-02(C)(1); Coverage of Hospice Services Under Hospital Insurance (revised May 8, 2015), *Medicare Benefit Policy Manual* (CMS Pub. 100-02), Chapter 9, §§10 and 20, available at <http://bit.ly/2buhmoF>.

[35] R.C. 3727.71.

[36] R.C. 3727.70(F).

[37] R.C. 3727.70(B).

communicated this fact to hospital staff. It excludes hospitals and other institutional settings.[38]

Hospital duties if lay caregiver designation is made

If a patient or guardian makes a lay caregiver designation, a hospital must do both of the following:[39]

--To the extent the information is available, record in the patient's medical record the lay caregiver's name, address, telephone number, electronic mail address, and relationship to the patient; and

--Request from the patient or guardian consent to disclose the patient's medical information to the lay caregiver in accordance with hospital policy and state and federal law.

If a patient or guardian declines to make a lay caregiver designation, the hospital must note that decision in the patient's medical record. The bill provides that under those circumstances, the hospital will have no other obligation regarding a lay caregiver designation.[40]

Notification regarding discharge

A hospital that intends to discharge a patient, or transfer a patient to another hospital or facility, must notify the patient's lay caregiver of that intent as soon as practicable. This requirement does not apply if the patient or guardian has not given consent to disclose the patient's medical information to the lay caregiver.[41]

Revocation

Under the bill, a patient or guardian may revoke a lay caregiver designation at any time before the patient's discharge by communicating that intent to hospital staff. After revocation, a new lay caregiver designation may be completed in accordance with the bill.[42]

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[38] R.C. 3727.70(H).

[39] R.C. 3727.72(A).

[40] R.C. 3727.72(B).

[41] R.C. 3727.74.

[42] R.C. 3727.73.

Significance of the existence or absence of a lay caregiver designation

The bill specifies that (1) its provisions do not require a patient or guardian to make a lay caregiver designation, (2) the existence of a lay caregiver designation does not obligate any individual to perform after-care, and (3) the existence or absence of a lay caregiver designation does not affect the provision of health care to the patient.[43]

Discharge plan

Content; timing

The bill requires a hospital that intends to discharge a patient to create a discharge plan and review that plan with the patient or the patient's guardian. The plan must be created in accordance with state and federal law and hospital policy. The review must be done as soon as practicable and be conducted in accordance with the bill (see "**Review**," below).[44]

The bill authorizes a discharge plan to include (1) a description of the tasks that are necessary to facilitate the patient's transition from the hospital to the patient's residence and (2) contact information for the health care providers or providers of community or long-term care services that the hospital and the patient or guardian believe are necessary for successful implementation of the discharge plan.[45] If a lay caregiver designation is made and the discharging health care professional has determined that the lay caregiver is to have a role in the discharge plan, the bill permits the plan to include:[46]

--The lay caregiver's name, address, telephone number, electronic mail address, and relationship to the patient, if available;

--A description of all after-care tasks to be performed by the lay caregiver, taking into account the lay caregiver's capability to perform such tasks; and

--Any other information the hospital believes is necessary for successful implementation of the discharge plan.

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[43] R.C. 3727.77.

[44] R.C. 3727.75(A).

[45] R.C. 3727.75(B)(1).

[46] R.C. 3727.75(B)(2).

The bill defines a "discharging health care professional" as a health care professional who is authorized under existing law to admit a patient to a hospital and has assumed responsibility for directing the creation of the patient's discharge plan.[47]

Review

A hospital that has created a discharge plan must review the plan with the patient or the patient's guardian. If a lay caregiver has been designated for the patient, the discharging health care professional has determined that the lay caregiver's participation in the review would be appropriate, and the lay caregiver is available within a reasonable amount of time, the hospital must arrange for the lay caregiver to also participate in the review.[48] In addition, the review must be conducted in a manner that is culturally sensitive to each individual who participates in the review. In accordance with state and federal law and if appropriate, the hospital must arrange for an interpreter to be present during the instruction.[49]

A review of a discharge plan must include the following components:[50]

--If the discharging health care professional determines that it is appropriate, a live demonstration of each task described in the discharge plan performed by a hospital employee or an individual under contract with the hospital to provide the instruction;

--An opportunity for each participant to ask questions and receive responses; and

--Any other component the hospital believes is necessary to ensure that each participant receives adequate instruction on the tasks described in the discharge plan.

The hospital must document information concerning the instruction provided in the patient's medical record. The information must include the date and time the instruction was provided and a description of the instruction content.[51] The bill also specifies that it is the General Assembly's intent that execution of the components described above not unreasonably delay a patient's discharge.[52]

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[47] R.C. 3727.70(D).

[48] R.C. 3727.75(A).

[49] R.C. 3727.76(A).

[50] R.C. 3727.76(B).

[51] R.C. 3727.76(C).

[52] R.C. 3727.76(B)(2).

Discharging health care professional immunity

The bill specifies that a discharging health care professional is immune from criminal prosecution, civil liability, and professional disciplinary action for an event or occurrence that allegedly arises out of the professional's determination that a patient's lay caregiver should or should not participate in the review of the patient's discharge plan.[53]

Rulemaking

The bill authorizes the Ohio Department of Health to adopt rules as necessary to implement the bill's provisions. The rules must be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).[54]

Statutory intent

The bill specifies that it is the General Assembly's intent that the bill's provisions not be construed to do any of the following:[55]

--Interfere with the authority of a patient's attorney-in-fact under a durable attorney for health care or a patient's proxy under a declaration for mental health treatment;

--Create a right of action against a hospital or an employee, agent, or contractor of the hospital;

--Create a liability for a hospital or an employee, agent, or contractor of the hospital;

--Limit, impair, or supersede any right or remedy that a person has under any other statute, rule, regulation, or Ohio common law; or

--Alter the obligations of an insurer under a health insurance policy, contract, or plan.

MEMORY CARE UNITS

The bill requires the Director of Aging and the Director of Health to jointly develop recommendations regarding the establishment of standards and procedures for

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[53] R.C. 3727.75(C).

[54] R.C. 3727.79.

[55] R.C. 3727.78.

the operation of memory care units in Ohio, as well as quality-of-care metrics to be used in measuring the performance of such units. The directors must submit the recommendations to the General Assembly not later than six months after the bill's effective date.[56]

AUTISM COVERAGE

Requirement of coverage

The bill requires that any health insurance plan issued by a health plan issuer provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. The bill applies to health insuring corporations, sickness and accident insurers, and multiple employer welfare arrangements. The bill prohibits a health plan issuer from terminating an individual's coverage, or from refusing to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder. The bill does not apply to nongrandfathered plans in the individual and small group markets, Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care, or other limited benefit hospital insurance policies.[57]

Under the bill, the health insurance plan must stipulate that coverage be contingent upon both of the following:

- The covered individual receiving prior authorization for the services in question;
- The services in question being prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism.[58]

Coverage minimums

The bill imposes the following coverage minimums:

- For speech and language therapy or occupational therapy for a covered individual under the age of 14 that is performed by a licensed therapist, 20 visits per year for each service;

[56] Section 5.

[57] R.C. 1739.05, 1751.84(A), and 3923.84(A).

[58] R.C. 1739.05, 1751.84(C)(2), and 3923.84(C)(2).

- For clinical therapeutic intervention for a covered individual under the age of 14 that is provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate Ohio agency to perform such services in accordance with a health treatment plan, 20 hours per week;

- For mental or behavioral health outpatient services for a covered individual under the age of 14 that are performed by a licensed psychologist, psychiatrist, or physician providing consultation, assessment, development, or oversight of treatment plans, 30 visits per year.[59]

The bill prohibits autism spectrum disorder coverage from being subject to dollar limits, deductibles, or coinsurance provisions that are less favorable than those that apply to substantially all the medical and surgical benefits under the health insurance plan. Also, the bill's provisions are not to be construed as limiting coverage that is otherwise available under the health insurance plan.[60]

Review of treatment plan

The bill allows a health plan issuer to review a covered individual's treatment plan with regard to outpatient services on an annual basis. The health plan issuer may conduct such a review on a more frequent basis if the covered individual's physician agrees that more frequent reviews are necessary. If an agreement for more frequent reviews occurs, the agreement applies only to the specific covered individual for whom it was created and not to all individuals being treated for autism spectrum disorder by a physician or psychologist. The bill requires a health plan issuer to cover the cost of obtaining any review or treatment plan.[61]

Construction

The bill specifies that its provisions are not to be construed as affecting any obligation to provide services to an enrollee under an individualized family service plan, an individualized education program, or an individualized service plan.[62]

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[59] R.C. 1739.05, 1751.84(B), and 3923.84(B).

[60] R.C. 1739.05, 1751.84(A) and (C)(1), and 3923.84(A) and (C)(1).

[61] R.C. 1739.05, 1751.84(D), and 3923.84(D).

[62] R.C. 1739.05, 1751.84(E), and 3923.84(E).

Severability

The bill specifies that if the bill's provisions, or their application, are for any reason held to be invalid, the remainder of the provisions and their application are not affected.[63]

Exemption from review by the Superintendent of Insurance

The requirements of this bill may be considered mandated health benefits. Under R.C. 3901.71, no mandated health benefits legislation enacted by the General Assembly may be applied to any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the Administrative Procedure Act, that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or any political subdivision of the state, or by any agency or instrumentality of the state or any political subdivision of the state. The bill includes provisions that exempt its requirements from this restriction.[64]

Definitions

The bill enacts the following definitions:

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association available at the time an individual is first evaluated for suspected developmental delay.

"Clinical therapeutic intervention" means therapies supported by empirical evidence, which include applied behavioral analysis, that are necessary to develop,

[63] R.C. 1739.05, 1751.84(G), and 3923.84(G).

[64] R.C. 1751.84(A) and 3923.84(A).

maintain, or restore, to the maximum extent practicable, the function of an individual and that are provided by or under the supervision of any of the following:

- A certified Ohio behavior analyst;
- A licensed psychologist;
- A licensed professional counselor, social worker, or marriage and family therapist.

"Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

"Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic care" means services provided by a speech therapist, occupational therapist, or physical therapist licensed or certified in the state in which the person practices.

"Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician who is a developmental pediatrician or a licensed psychologist trained in autism who determines the care to be medically necessary, including any of the following:

- Clinical therapeutic intervention;
- Pharmacy care;
- Psychiatric care;
- Psychological care.

CRIMINAL PENALTY – ASSISTING SUICIDE

Assisting suicide

The bill generally prohibits a person from knowingly causing another to commit or attempt to commit suicide by either providing the physical means by which the person commits or attempts to commit suicide or participating in a physical act by which the person commits or attempts to commit suicide.[65] Whoever violates this prohibition is guilty of assisting suicide, a third degree felony.[66] The penalty for assisting suicide includes a prison term of 12, 18, 24, 30, 36, 42, 48, 54, or 60 months.[67]

HISTORY

ACTION	DATE
Introduced	02-17-16
Reported, H. Health & Aging	05-18-16
Passed House (92-5)	05-25-16
Reported, S. Health & Human Services	---

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[65] R.C. 3795.04(A).

[66] R.C. 3795.04(B).

[67] R.C. 2929.14(A)(3)(a).