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H.B. 579
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Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Russo

Yosef Schiff, Attorney

SUMMARY

- Requires health insurers to cover testing and treatment of and immunization against the novel coronavirus, regardless of whether the care is in- or out-of-network.
- Prohibits health insurers from imposing cost-sharing or medical management requirements for coronavirus services.
- Requires insurers to reimburse at the Medicare rate or the insurer's median in-network rate, depending on the service.
- Prohibits providers from balance billing patients for coronavirus services.
- Requires the Superintendent of Insurance to adopt rules to carry out the bill's provisions.
- Appropriates $20 million for COVID-19 testing and treatment costs provided to uninsured individuals.
- Declares an emergency.

DETAILED ANALYSIS

Insurance coverage

Coverage requirements

The bill requires a health plan issuer (an entity that contracts to provide or reimburse health care costs under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan) to reimburse a provider for all of the following regardless of whether the following are provided to a covered person on an in-network or out-of-network basis:

- The detection of SARS-CoV-2 (the virus that causes COVID-19);

- The diagnosis of COVID-19 (the disease caused by the SARS-CoV-2 virus);
- The treatment of COVID-19; and
- Immunization against SARS-CoV-2.[1]

The services and items required to be covered include those identified in the federal Families First Coronavirus Response Act, a federal law requiring most insurers to cover SARS-CoV-2 testing and COVID-19 diagnosis during the ongoing national public health emergency. These items and services are those used in the diagnosis of disease or other conditions as well as any items or services provided during an office or hospital visit that results in testing.[2] Unlike the federal law, this bill (1) also covers short-term limited duration plans (a type of health benefit plan that lasts less than one year) and benefit contracts offered by fraternal benefit societies (a type of organization formed to provide some kind of benefit for its members, such as a local Elks Lodge), and (2) requires coverage from the bill's effective date onward, not just during the period of emergency.[3]

The bill prohibits a health benefit plan (a contract offered by a health plan issuer to provide for or pay for health care services) from imposing cost-sharing or prior authorization, step therapy (a protocol in which a health plan issuer requires a person to try a cheaper drug before moving on to a more expensive one), or other medical management requirements for these services. It also requires a health plan issuer to provide coverage regardless of whether the person has previously received coverage for testing or treatment. Lastly, the bill prohibits a health plan issuer form denying coverage because of a negative diagnosis.[4]

Reimbursement rate

The reimbursement required under the bill for detection, diagnosis, and immunization is, at minimum, the Medicare reimbursement rate. The rate required for treatment is, at minimum, the median amount negotiated with providers for the service, item, or drug in question in that geographic region under that health benefit plan as determined by the Superintendent of Insurance.[5]

Balance billing

For care provided in Ohio, the bill prohibits a provider from billing a covered person (any person covered under a health benefit plan) for the difference between the health plan issuer's

[1] R.C. 3902.51(A)(1).

[2] Pub. L. No. 116-127, Sec. 6001(a).

[3] R.C. 3902.50(B) and 3902.51(A)(1) and (2) and Section 2 of the bill.

[4] R.C. 3902.51(A)(3), (B), and (C).

[5] R.C. 3902.53(A).

reimbursement and the provider's charge for the diagnostic and treatment services described above.[6]

Rules

The bill requires the Superintendent of Insurance to adopt rules to carry out the bill's provisions and exempts such rules from the current requirement that for each new administrative rule, two existing rules must be eliminated.[7]

Effective date and application

As an emergency measure, the bill is effective upon its passage and applies to all health benefit plans, including those in existence as of the bill's effective date.[8]

Testing and treatment of uninsured individuals

The bill appropriates funds for the Department of Health to use for COVID-19 testing of, and treatment provided to, uninsured individuals. The bill appropriates $20 million in FY 2020 in GRF appropriation item 440477, Emergency Preparedness and Response, within the Ohio Department of Health's budget. The bill allows the unexpended, unencumbered balance of the appropriation to be reappropriated at the end of FY 2020 to FY 2021.

The bill also specifies that if there are insufficient funds in this appropriation item for COVID-19 testing and treatment for uninsured individuals, at the request of the Director of Health, and with the approval of the Controlling Board, the Director of Budget and Management may transfer cash from any available funds to help pay for these costs. The bill specifies that these transfers will only take place during the period of the emergency declared by Executive Order 2020-01D, issued on March 9, 2020, and for six months thereafter. Upon approval by the Controlling Board, the transferred amounts are appropriated.[9]

Exemption from review by the Superintendent of Insurance

The bill's requirement that a health benefit plan cover COVID-19 testing, diagnosis, and treatment 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),[10] and to employee benefit plans established or modified by the state or any of its political subdivisions. ERISA

[6] R.C. 3902.50(B) and 3902.52.

[7] R.C. 3902.53(B); R.C. 121.95, not in the bill.

[8] Sections 2 and 6 of the bill.

[9] Sections 3 to 5 of the bill.

[10] 29 United States Code (U.S.C.) 1001, as amended.

appears to preempt any state regulation of such plans.[11] The bill contains provisions that exempt its requirements from this restriction.

COMMENT

By applying to all health benefit plans in existence as of the bill's effective date, rather than only those entered into or renewed on or after that date, the bill raises questions under the Contracts Clauses of the U.S. and Ohio Constitutions, as well as takings under the Fifth Amendment to the U.S. Constitution.

Under the Contracts Clauses of the U.S. and Ohio Constitutions, the General Assembly is prohibited from enacting laws that impair contractual obligations. These prohibitions are not absolute, however; they do not absolutely prevent a state from abridging contractual obligations when exercising its police power and passing laws for the protection of public health, safety, and welfare. Rather, they prohibit a "substantial" impairment of existing contractual obligations unless the state can *justify the impairment on the basis of an overriding public interest and the impairing measure is appropriately tailored to serve that interest*. The more substantial the impairment, the more closely a court will scrutinize the law. In looking at whether an impairment is substantial, courts look to (1) the extent to which reasonable expectations in the contract are disrupted and (2) whether a party has relied on an obligation that is impaired by legislation, such as when the legislation impairs the express terms of a contract.[12] Whether the impairment is substantial, whether the public interest is overriding, and whether the measure is appropriately tailored are ultimately questions for a court to decide.

Related to the impairment issue is the issue of takings. Under the Fifth Amendment to the U.S. Constitution, private property must not "be taken for public use, without just compensation." It is possible that a mandated payment by one party (the insurer) to another (the covered person) that is not required under their current contract may be viewed as a taking. The next question would be whether the taking was for a public use. The term "public use" is broadly interpreted by the U.S. Supreme Court to mean more than just use by the public; it encompasses takings that serve a public purpose.[13] If a court views the bill's requirements as a taking for a public purpose, then it must be compensated.

[11] 29 U.S.C. 1144.

[12] U.S. Constitution, Article I, Section 10; Ohio Constitution, Article II, Section 28; *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216, 2003-Ohio-5849; *City of Middletown v. Ferguson*, 25 Ohio St.3d 71 (1986), *cert. denied, Sticklen v. Middletown*, 479 U.S. 1034 (1987); and *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234 (1978).

[13] *Thompson v. Consolidated Gas Utilities Corp.*, 300 U.S. 55, 80 (1937).

HISTORY

Action	Date
Introduced	03-23-20

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