

As Introduced

CORRECTED VERSION

**132nd General Assembly
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S. B. No. 87

Senators Hackett, Huffman

A BILL

To amend sections 1753.09, 3901.21, 3963.01, 1
3963.02, and 3963.03 of the Revised Code to 2
prohibit a health insurer from establishing a 3
fee schedule for dental providers for services 4
that are not covered by any contract or 5
participating provider agreement between the 6
health insurer and the dental provider. 7

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1753.09, 3901.21, 3963.01, 8
3963.02, and 3963.03 of the Revised Code be amended to read as 9
follows: 10

Sec. 1753.09. (A) Except as provided in division (D) of 11
this section, prior to terminating the participation of a 12
provider on the basis of the participating provider's failure to 13
meet the health insuring corporation's standards for quality or 14
utilization in the delivery of health care services, a health 15
insuring corporation shall give the participating provider 16
notice of the reason or reasons for its decision to terminate 17
the provider's participation and an opportunity to take 18

corrective action. The health insuring corporation shall develop 19
a performance improvement plan in conjunction with the 20
participating provider. If after being afforded the opportunity 21
to comply with the performance improvement plan, the 22
participating provider fails to do so, the health insuring 23
corporation may terminate the participation of the provider. 24

(B) (1) A participating provider whose participation has 25
been terminated under division (A) of this section may appeal 26
the termination to the appropriate medical director of the 27
health insuring corporation. The medical director shall give the 28
participating provider an opportunity to discuss with the 29
medical director the reason or reasons for the termination. 30

(2) If a satisfactory resolution of a participating 31
provider's appeal cannot be reached under division (B) (1) of 32
this section, the participating provider may appeal the 33
termination to a panel composed of participating providers who 34
have comparable or higher levels of education and training than 35
the participating provider making the appeal. A representative 36
of the participating provider's specialty shall be a member of 37
the panel, if possible. This panel shall hold a hearing, and 38
shall render its recommendation in the appeal within thirty days 39
after holding the hearing. The recommendation shall be presented 40
to the medical director and to the participating provider. 41

(3) The medical director shall review and consider the 42
panel's recommendation before making a decision. The decision 43
rendered by the medical director shall be final. 44

(C) A provider's status as a participating provider shall 45
remain in effect during the appeal process set forth in division 46
(B) of this section unless the termination was based on any of 47
the reasons listed in division (D) of this section. 48

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

(E) Divisions (A) to (D) of this section apply only to providers who are natural persons.

(F) (1) Nothing in this section prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services.

(2) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract.

(3) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract described in division ~~(E)~~ (F) (2) of section 3963.02 of the Revised Code, except that, notwithstanding any provision of a contract described in that division, this section applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F) (1) and (2) of this section.

(G) The superintendent of insurance may adopt rules as 79
necessary to implement and enforce sections 1753.06, 1753.07, 80
and 1753.09 of the Revised Code. Such rules shall be adopted in 81
accordance with Chapter 119. of the Revised Code. 82

Sec. 3901.21. The following are hereby defined as unfair 83
and deceptive acts or practices in the business of insurance: 84

(A) Making, issuing, circulating, or causing or permitting 85
to be made, issued, or circulated, or preparing with intent to 86
so use, any estimate, illustration, circular, or statement 87
misrepresenting the terms of any policy issued or to be issued 88
or the benefits or advantages promised thereby or the dividends 89
or share of the surplus to be received thereon, or making any 90
false or misleading statements as to the dividends or share of 91
surplus previously paid on similar policies, or making any 92
misleading representation or any misrepresentation as to the 93
financial condition of any insurer as shown by the last 94
preceding verified statement made by it to the insurance 95
department of this state, or as to the legal reserve system upon 96
which any life insurer operates, or using any name or title of 97
any policy or class of policies misrepresenting the true nature 98
thereof, or making any misrepresentation or incomplete 99
comparison to any person for the purpose of inducing or tending 100
to induce such person to purchase, amend, lapse, forfeit, 101
change, or surrender insurance. 102

Any written statement concerning the premiums for a policy 103
which refers to the net cost after credit for an assumed 104
dividend, without an accurate written statement of the gross 105
premiums, cash values, and dividends based on the insurer's 106
current dividend scale, which are used to compute the net cost 107
for such policy, and a prominent warning that the rate of 108

dividend is not guaranteed, is a misrepresentation for the 109
purposes of this division. 110

(B) Making, publishing, disseminating, circulating, or 111
placing before the public or causing, directly or indirectly, to 112
be made, published, disseminated, circulated, or placed before 113
the public, in a newspaper, magazine, or other publication, or 114
in the form of a notice, circular, pamphlet, letter, or poster, 115
or over any radio station, or in any other way, or preparing 116
with intent to so use, an advertisement, announcement, or 117
statement containing any assertion, representation, or 118
statement, with respect to the business of insurance or with 119
respect to any person in the conduct of the person's insurance 120
business, which is untrue, deceptive, or misleading. 121

(C) Making, publishing, disseminating, or circulating, 122
directly or indirectly, or aiding, abetting, or encouraging the 123
making, publishing, disseminating, or circulating, or preparing 124
with intent to so use, any statement, pamphlet, circular, 125
article, or literature, which is false as to the financial 126
condition of an insurer and which is calculated to injure any 127
person engaged in the business of insurance. 128

(D) Filing with any supervisory or other public official, 129
or making, publishing, disseminating, circulating, or delivering 130
to any person, or placing before the public, or causing directly 131
or indirectly to be made, published, disseminated, circulated, 132
delivered to any person, or placed before the public, any false 133
statement of financial condition of an insurer. 134

Making any false entry in any book, report, or statement 135
of any insurer with intent to deceive any agent or examiner 136
lawfully appointed to examine into its condition or into any of 137
its affairs, or any public official to whom such insurer is 138

required by law to report, or who has authority by law to 139
examine into its condition or into any of its affairs, or, with 140
like intent, willfully omitting to make a true entry of any 141
material fact pertaining to the business of such insurer in any 142
book, report, or statement of such insurer, or mutilating, 143
destroying, suppressing, withholding, or concealing any of its 144
records. 145

(E) Issuing or delivering or permitting agents, officers, 146
or employees to issue or deliver agency company stock or other 147
capital stock or benefit certificates or shares in any common- 148
law corporation or securities or any special or advisory board 149
contracts or other contracts of any kind promising returns and 150
profits as an inducement to insurance. 151

(F) Making or permitting any unfair discrimination among 152
individuals of the same class and equal expectation of life in 153
the rates charged for any contract of life insurance or of life 154
annuity or in the dividends or other benefits payable thereon, 155
or in any other of the terms and conditions of such contract. 156

(G) (1) Except as otherwise expressly provided by law, 157
knowingly permitting or offering to make or making any contract 158
of life insurance, life annuity or accident and health 159
insurance, or agreement as to such contract other than as 160
plainly expressed in the contract issued thereon, or paying or 161
allowing, or giving or offering to pay, allow, or give, directly 162
or indirectly, as inducement to such insurance, or annuity, any 163
rebate of premiums payable on the contract, or any special favor 164
or advantage in the dividends or other benefits thereon, or any 165
valuable consideration or inducement whatever not specified in 166
the contract; or giving, or selling, or purchasing, or offering 167
to give, sell, or purchase, as inducement to such insurance or 168

annuity or in connection therewith, any stocks, bonds, or other securities, or other obligations of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(2) Nothing in division (F) or division (G)(1) of this section shall be construed as prohibiting any of the following practices: (a) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; (c) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(H) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that a policy of life insurance is, is the equivalent of, or represents shares of capital stock or any rights or options to subscribe for or otherwise acquire any such shares in the life insurance company issuing that policy or any other company.

(I) Making, issuing, circulating, or causing or permitting to be made, issued or circulated, or preparing with intent to so issue, any statement to the effect that payments to a policyholder of the principal amounts of a pure endowment are other than payments of a specific benefit for which specific premiums have been paid.	199 200 201 202 203 204
(J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance.	205 206 207 208 209 210 211 212 213
(K) Aiding or abetting another to violate this section.	214
(L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder.	215 216 217 218
(M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder, or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever.	219 220 221 222 223 224 225 226
(N) Refusing to make available disability income insurance	227

solely because the applicant's principal occupation is that of 228
managing a household. 229

(O) Refusing, when offering maternity benefits under any 230
individual or group sickness and accident insurance policy, to 231
make maternity benefits available to the policyholder for the 232
individual or individuals to be covered under any comparable 233
policy to be issued for delivery in this state, including family 234
members if the policy otherwise provides coverage for family 235
members. Nothing in this division shall be construed to prohibit 236
an insurer from imposing a reasonable waiting period for such 237
benefits under an individual sickness and accident insurance 238
policy issued to an individual who is not a federally eligible 239
individual or a nonemployer-related group sickness and accident 240
insurance policy, but in no event shall such waiting period 241
exceed two hundred seventy days. 242

For purposes of division (O) of this section, "federally 243
eligible individual" means an eligible individual as defined in 244
45 C.F.R. 148.103. 245

(P) Using, or permitting to be used, a pattern settlement 246
as the basis of any offer of settlement. As used in this 247
division, "pattern settlement" means a method by which liability 248
is routinely imputed to a claimant without an investigation of 249
the particular occurrence upon which the claim is based and by 250
using a predetermined formula for the assignment of liability 251
arising out of occurrences of a similar nature. Nothing in this 252
division shall be construed to prohibit an insurer from 253
determining a claimant's liability by applying formulas or 254
guidelines to the facts and circumstances disclosed by the 255
insurer's investigation of the particular occurrence upon which 256
a claim is based. 257

(Q) Refusing to insure, or refusing to continue to insure, 258
or limiting the amount, extent, or kind of life or sickness and 259
accident insurance or annuity coverage available to an 260
individual, or charging an individual a different rate for the 261
same coverage solely because of blindness or partial blindness. 262
With respect to all other conditions, including the underlying 263
cause of blindness or partial blindness, persons who are blind 264
or partially blind shall be subject to the same standards of 265
sound actuarial principles or actual or reasonably anticipated 266
actuarial experience as are sighted persons. Refusal to insure 267
includes, but is not limited to, denial by an insurer of 268
disability insurance coverage on the grounds that the policy 269
defines "disability" as being presumed in the event that the 270
eyesight of the insured is lost. However, an insurer may exclude 271
from coverage disabilities consisting solely of blindness or 272
partial blindness when such conditions existed at the time the 273
policy was issued. To the extent that the provisions of this 274
division may appear to conflict with any provision of section 275
3999.16 of the Revised Code, this division applies. 276

(R) (1) Directly or indirectly offering to sell, selling, 277
or delivering, issuing for delivery, renewing, or using or 278
otherwise marketing any policy of insurance or insurance product 279
in connection with or in any way related to the grant of a 280
student loan guaranteed in whole or in part by an agency or 281
commission of this state or the United States, except insurance 282
that is required under federal or state law as a condition for 283
obtaining such a loan and the premium for which is included in 284
the fees and charges applicable to the loan; or, in the case of 285
an insurer or insurance agent, knowingly permitting any lender 286
making such loans to engage in such acts or practices in 287
connection with the insurer's or agent's insurance business. 288

(2) Except in the case of a violation of division (G) of 289
this section, division (R)(1) of this section does not apply to 290
either of the following: 291

(a) Acts or practices of an insurer, its agents, 292
representatives, or employees in connection with the grant of a 293
guaranteed student loan to its insured or the insured's spouse 294
or dependent children where such acts or practices take place 295
more than ninety days after the effective date of the insurance; 296

(b) Acts or practices of an insurer, its agents, 297
representatives, or employees in connection with the 298
solicitation, processing, or issuance of an insurance policy or 299
product covering the student loan borrower or the borrower's 300
spouse or dependent children, where such acts or practices take 301
place more than one hundred eighty days after the date on which 302
the borrower is notified that the student loan was approved. 303

(S) Denying coverage, under any health insurance or health 304
care policy, contract, or plan providing family coverage, to any 305
natural or adopted child of the named insured or subscriber 306
solely on the basis that the child does not reside in the 307
household of the named insured or subscriber. 308

(T)(1) Using any underwriting standard or engaging in any 309
other act or practice that, directly or indirectly, due solely 310
to any health status-related factor in relation to one or more 311
individuals, does either of the following: 312

(a) Terminates or fails to renew an existing individual 313
policy, contract, or plan of health benefits, or a health 314
benefit plan issued to an employer, for which an individual 315
would otherwise be eligible; 316

(b) With respect to a health benefit plan issued to an 317

employer, excludes or causes the exclusion of an individual from 318
coverage under an existing employer-provided policy, contract, 319
or plan of health benefits. 320

(2) The superintendent of insurance may adopt rules in 321
accordance with Chapter 119. of the Revised Code for purposes of 322
implementing division (T) (1) of this section. 323

(3) For purposes of division (T) (1) of this section, 324
"health status-related factor" means any of the following: 325

(a) Health status; 326

(b) Medical condition, including both physical and mental 327
illnesses; 328

(c) Claims experience; 329

(d) Receipt of health care; 330

(e) Medical history; 331

(f) Genetic information; 332

(g) Evidence of insurability, including conditions arising 333
out of acts of domestic violence; 334

(h) Disability. 335

(U) With respect to a health benefit plan issued to a 336
small employer, as those terms are defined in section 3924.01 of 337
the Revised Code, negligently or willfully placing coverage for 338
adverse risks with a certain carrier, as defined in section 339
3924.01 of the Revised Code. 340

(V) Using any program, scheme, device, or other unfair act 341
or practice that, directly or indirectly, causes or results in 342
the placing of coverage for adverse risks with another carrier, 343
as defined in section 3924.01 of the Revised Code. 344

(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice.

(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company.

(Y) (1) (a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or contract of life insurance, or limiting coverage under or refusing to issue any individual policy or contract of health insurance, for the reason that the insured or applicant for insurance is or has been a victim of domestic violence;

(b) Adding a surcharge or rating factor to a premium of any individual policy or contract of life or health insurance for the reason that the insured or applicant for insurance is or has been a victim of domestic violence;

(c) Denying coverage under, or limiting coverage under, any policy or contract of life or health insurance, for the reason that a claim under the policy or contract arises from an incident of domestic violence;

(d) Inquiring, directly or indirectly, of an insured under, or of an applicant for, a policy or contract of life or health insurance, as to whether the insured or applicant is or has been a victim of domestic violence, or inquiring as to whether the insured or applicant has sought shelter or protection from domestic violence or has sought medical or psychological treatment as a victim of domestic violence.

(2) Nothing in division (Y) (1) of this section shall be

construed to prohibit an insurer from inquiring as to, or from 374
underwriting or rating a risk on the basis of, a person's 375
physical or mental condition, even if the condition has been 376
caused by domestic violence, provided that all of the following 377
apply: 378

(a) The insurer routinely considers the condition in 379
underwriting or in rating risks, and does so in the same manner 380
for a victim of domestic violence as for an insured or applicant 381
who is not a victim of domestic violence; 382

(b) The insurer does not refuse to issue any policy or 383
contract of life or health insurance or cancel or refuse to 384
renew any policy or contract of life insurance, solely on the 385
basis of the condition, except where such refusal to issue, 386
cancellation, or refusal to renew is based on sound actuarial 387
principles or is related to actual or reasonably anticipated 388
experience; 389

(c) The insurer does not consider a person's status as 390
being or as having been a victim of domestic violence, in 391
itself, to be a physical or mental condition; 392

(d) The underwriting or rating of a risk on the basis of 393
the condition is not used to evade the intent of division (Y) (1) 394
of this section, or of any other provision of the Revised Code. 395

(3) (a) Nothing in division (Y) (1) of this section shall be 396
construed to prohibit an insurer from refusing to issue a policy 397
or contract of life insurance insuring the life of a person who 398
is or has been a victim of domestic violence if the person who 399
committed the act of domestic violence is the applicant for the 400
insurance or would be the owner of the insurance policy or 401
contract. 402

(b) Nothing in division (Y) (2) of this section shall be 403
construed to permit an insurer to cancel or refuse to renew any 404
policy or contract of health insurance in violation of the 405
"Health Insurance Portability and Accountability Act of 1996," 406
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 407
manner that violates or is inconsistent with any provision of 408
the Revised Code that implements the "Health Insurance 409
Portability and Accountability Act of 1996." 410

(4) An insurer is immune from any civil or criminal 411
liability that otherwise might be incurred or imposed as a 412
result of any action taken by the insurer to comply with 413
division (Y) of this section. 414

(5) As used in division (Y) of this section, "domestic 415
violence" means any of the following acts: 416

(a) Knowingly causing or attempting to cause physical harm 417
to a family or household member; 418

(b) Recklessly causing serious physical harm to a family 419
or household member; 420

(c) Knowingly causing, by threat of force, a family or 421
household member to believe that the person will cause imminent 422
physical harm to the family or household member. 423

For the purpose of division (Y) (5) of this section, 424
"family or household member" has the same meaning as in section 425
2919.25 of the Revised Code. 426

Nothing in division (Y) (5) of this section shall be 427
construed to require, as a condition to the application of 428
division (Y) of this section, that the act described in division 429
(Y) (5) of this section be the basis of a criminal prosecution. 430

(Z) Disclosing a coroner's records by an insurer in 431
violation of section 313.10 of the Revised Code. 432

(AA) Making, issuing, circulating, or causing or 433
permitting to be made, issued, or circulated any statement or 434
representation that a life insurance policy or annuity is a 435
contract for the purchase of funeral goods or services. 436

(BB) (1) Setting or requiring the insurer's approval of 437
fees for dental services that are not covered dental services, 438
as defined in section 3963.01 of the Revised Code, or making 439
available any health benefit plan that sets fees for dental 440
services that are not covered dental care services. 441

(2) Nothing in division (BB) (1) of this section shall be 442
construed to apply to any health benefit plan subject to 443
regulation by the "Employee Retirement Income Security Act of 444
1974," 29 U.S.C. 1001, et seq., as amended. 445

(CC) With respect to private passenger automobile 446
insurance, charging premium rates that are excessive, 447
inadequate, or unfairly discriminatory, pursuant to division (D) 448
of section 3937.02 of the Revised Code, based solely on the 449
location of the residence of the insured. 450

The enumeration in sections 3901.19 to 3901.26 of the 451
Revised Code of specific unfair or deceptive acts or practices 452
in the business of insurance is not exclusive or restrictive or 453
intended to limit the powers of the superintendent of insurance 454
to adopt rules to implement this section, or to take action 455
under other sections of the Revised Code. 456

This section does not prohibit the sale of shares of any 457
investment company registered under the "Investment Company Act 458
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 459

policies, annuities, or other contracts described in section 460
3907.15 of the Revised Code. 461

As used in this section, "estimate," "statement," 462
"representation," "misrepresentation," "advertisement," or 463
"announcement" includes oral or written occurrences. 464

Sec. 3963.01. As used in this chapter: 465

(A) "Affiliate" means any person or entity that has 466
ownership or control of a contracting entity, is owned or 467
controlled by a contracting entity, or is under common ownership 468
or control with a contracting entity. 469

(B) "Basic health care services" has the same meaning as 470
in division (A) of section 1751.01 of the Revised Code, except 471
that it does not include any services listed in that division 472
that are provided by a pharmacist or nursing home. 473

(C) "Contracting entity" means any person that has a 474
primary business purpose of contracting with participating 475
providers for the delivery of health care services. 476

(D) "Covered dental services" means dental services for 477
which a reimbursement is available under an enrollee's health 478
benefit plan contract, or for which a reimbursement would be 479
available but for the application of contractual limitations 480
such as a deductible, copayment, coinsurance, waiting period, 481
annual or lifetime maximum, frequency limitation, alternative 482
benefit payment, or any other limitation. 483

(E) "Credentialing" means the process of assessing and 484
validating the qualifications of a provider applying to be 485
approved by a contracting entity to provide basic health care 486
services, specialty health care services, or supplemental health 487
care services to enrollees. 488

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following:

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider;

(2) Payment for a different procedure code than the procedure code originally billed by a participating provider;

(3) A reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date.

~~(F)~~ (G) "Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.

~~(G)~~ (H) "Enrollee" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of medicaid, and includes all of the following terms:

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code;

(2) "Member" as defined by section 1739.01 of the Revised Code;

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code;	517 518
(4) "Beneficiary" as defined by section 3901.38 of the Revised Code.	519 520
(H) <u>(I)</u> "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees.	521 522 523 524 525
(I) <u>(J)</u> "Health care services" means basic health care services, specialty health care services, and supplemental health care services.	526 527 528
(J) <u>(K)</u> "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:	529 530 531 532 533 534 535
(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;	536 537 538 539
(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;	540 541 542 543
(3) An administrative change that may significantly increase the provider's administrative expense, the specific	544 545

applicability of which is clearly identified in the contract; 546

(4) Changes to an existing prior authorization, 547
precertification, notification, or referral program that do not 548
substantially increase the provider's administrative expense; 549

(5) Changes to an edit program or to specific edits if the 550
participating provider is provided notice of the changes 551
pursuant to division (A) (1) of section 3963.04 of the Revised 552
Code and the notice includes information sufficient for the 553
provider to determine the effect of the change; 554

(6) Changes to a health care contract described in 555
division (B) of section 3963.04 of the Revised Code. 556

~~(K)~~ (L) "Participating provider" means a provider that has 557
a health care contract with a contracting entity and is entitled 558
to reimbursement for health care services rendered to an 559
enrollee under the health care contract. 560

~~(L)~~ (M) "Payer" means any person that assumes the 561
financial risk for the payment of claims under a health care 562
contract or the reimbursement for health care services provided 563
to enrollees by participating providers pursuant to a health 564
care contract. 565

~~(M)~~ (N) "Primary enrollee" means a person who is 566
responsible for making payments for participation in a health 567
care plan or an enrollee whose employment or other status is the 568
basis of eligibility for enrollment in a health care plan. 569

~~(N)~~ (O) "Procedure codes" includes the American medical 570
association's current procedural terminology code, the American 571
dental association's current dental terminology, and the centers 572
for medicare and medicaid services health care common procedure 573
coding system. 574

~~(O)~~(P) "Product" means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

- (1) A health maintenance organization or other product provided by a health insuring corporation;
- (2) A preferred provider organization;
- (3) Medicare;
- (4) Medicaid;
- (5) Workers' compensation.

~~(P)~~(Q) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice registered nurse, occupational therapist, massage therapist, physical therapist, licensed professional counselor, licensed professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, pediatric respite care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds.

~~(Q)~~(R) "Specialty health care services" has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a

pharmacist or a nursing home. 604

~~(R)~~(S) "Supplemental health care services" has the same 605
meaning as in division (B) of section 1751.01 of the Revised 606
Code, except that it does not include any services listed in 607
that division that are provided by a pharmacist or nursing home. 608

Sec. 3963.02. (A) (1) No contracting entity shall sell, 609
rent, or give a third party the contracting entity's rights to a 610
participating provider's services pursuant to the contracting 611
entity's health care contract with the participating provider 612
unless one of the following applies: 613

(a) The third party accessing the participating provider's 614
services under the health care contract is an employer or other 615
entity providing coverage for health care services to its 616
employees or members, and that employer or entity has a contract 617
with the contracting entity or its affiliate for the 618
administration or processing of claims for payment for services 619
provided pursuant to the health care contract with the 620
participating provider. 621

(b) The third party accessing the participating provider's 622
services under the health care contract either is an affiliate 623
or subsidiary of the contracting entity or is providing 624
administrative services to, or receiving administrative services 625
from, the contracting entity or an affiliate or subsidiary of 626
the contracting entity. 627

(c) The health care contract specifically provides that it 628
applies to network rental arrangements and states that one 629
purpose of the contract is selling, renting, or giving the 630
contracting entity's rights to the services of the participating 631
provider, including other preferred provider organizations, and 632

the third party accessing the participating provider's services 633
is any of the following: 634

(i) A payer or a third-party administrator or other entity 635
responsible for administering claims on behalf of the payer; 636

(ii) A preferred provider organization or preferred 637
provider network that receives access to the participating 638
provider's services pursuant to an arrangement with the 639
preferred provider organization or preferred provider network in 640
a contract with the participating provider that is in compliance 641
with division (A) (1) (c) of this section, and is required to 642
comply with all of the terms, conditions, and affirmative 643
obligations to which the originally contracted primary 644
participating provider network is bound under its contract with 645
the participating provider, including, but not limited to, 646
obligations concerning patient steerage and the timeliness and 647
manner of reimbursement. 648

(iii) An entity that is engaged in the business of 649
providing electronic claims transport between the contracting 650
entity and the payer or third-party administrator and complies 651
with all of the applicable terms, conditions, and affirmative 652
obligations of the contracting entity's contract with the 653
participating provider including, but not limited to, 654
obligations concerning patient steerage and the timeliness and 655
manner of reimbursement. 656

(2) The contracting entity that sells, rents, or gives the 657
contracting entity's rights to the participating provider's 658
services pursuant to the contracting entity's health care 659
contract with the participating provider as provided in division 660
(A) (1) of this section shall do both of the following: 661

(a) Maintain a web page that contains a listing of third parties described in divisions (A) (1) (b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider.

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider.

(4) Except as provided in division (A) (1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract.

(B) (1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity.

(2) Division (B) (1) of this section shall not be construed 691
to do any of the following: 692

(a) Prohibit any participating provider from voluntarily 693
accepting an offer by a contracting entity to provide health 694
care services under all of the contracting entity's products; 695

(b) Prohibit any contracting entity from offering any 696
financial incentive or other form of consideration specified in 697
the health care contract for a participating provider to provide 698
health care services under all of the contracting entity's 699
products; 700

(c) Require any contracting entity to contract with a 701
participating provider to provide health care services for less 702
than all of the contracting entity's products if the contracting 703
entity does not wish to do so. 704

(3) (a) Notwithstanding division (B) (2) of this section, no 705
contracting entity shall require, as a condition of contracting 706
with the contracting entity, that the participating provider 707
accept any future product offering that the contracting entity 708
makes. 709

(b) If a participating provider refuses to accept any 710
future product offering that the contracting entity makes, the 711
contracting entity may terminate the health care contract based 712
on the participating provider's refusal upon written notice to 713
the participating provider no sooner than one hundred eighty 714
days after the refusal. 715

(4) Once the contracting entity and the participating 716
provider have signed the health care contract, it is presumed 717
that the financial incentive or other form of consideration that 718
is specified in the health care contract pursuant to division 719

(B) (2) (b) of this section is the financial incentive or other 720
form of consideration that was offered by the contracting entity 721
to induce the participating provider to enter into the contract. 722

(C) No contracting entity shall require, as a condition of 723
contracting with the contracting entity, that a participating 724
provider waive or ~~forego~~ forgo any right or benefit expressly 725
conferred upon a participating provider by state or federal law. 726
However, this division does not prohibit a contracting entity 727
from restricting a participating provider's scope of practice 728
for the services to be provided under the contract. 729

(D) No health care contract shall do any of the following: 730

(1) Prohibit any participating provider from entering into 731
a health care contract with any other contracting entity; 732

(2) Prohibit any contracting entity from entering into a 733
health care contract with any other provider; 734

(3) Preclude its use or disclosure for the purpose of 735
enforcing this chapter or other state or federal law, except 736
that a health care contract may require that appropriate 737
measures be taken to preserve the confidentiality of any 738
proprietary or trade-secret information. 739

(E) (1) No contracting entity shall require in any health 740
care contract that covers any dental services, either directly 741
or indirectly, that a participating provider who is a dentist 742
provide services to an enrollee at a fee set by, or a fee 743
subject to the approval of, the contracting entity unless the 744
dental services are covered dental services. 745

(2) To the extent that the provisions in division (E) (1) 746
of this section conflict with the provisions of the federal 747
"Employee Retirement Income Security Act of 1974," 29 U.S.C. 748

1001, et seq., as amended, the federal law shall control. 749

(F)(1) In addition to any other lawful reasons for 750
terminating a health care contract, a health care contract may 751
only be terminated under the circumstances described in division 752
(A) (3) of section 3963.04 of the Revised Code. 753

(2) If the health care contract provides for termination 754
for cause by either party, the health care contract shall state 755
the reasons that may be used for termination for cause, which 756
terms shall be reasonable. Once the contracting entity and the 757
participating provider have signed the health care contract, it 758
is presumed that the reasons stated in the health care contract 759
for termination for cause by either party are reasonable. 760
Subject to division ~~(E)~~(F)(3) of this section, the health care 761
contract shall state the time by which the parties must provide 762
notice of termination for cause and to whom the parties shall 763
give the notice. 764

(3) Nothing in divisions ~~(E)~~(F)(1) and (2) of this section 765
shall be construed as prohibiting any health insuring 766
corporation from terminating a participating provider's contract 767
for any of the causes described in divisions (A), (D), and (F) 768
(1) and (2) of section 1753.09 of the Revised Code. 769
Notwithstanding any provision in a health care contract pursuant 770
to division ~~(E)~~(F)(2) of this section, section 1753.09 of the 771
Revised Code applies to the termination of a participating 772
provider's contract for any of the causes described in divisions 773
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 774
Code. 775

(4) Subject to sections 3963.01 to 3963.11 of the Revised 776
Code, nothing in this section prohibits the termination of a 777
health care contract without cause if the health care contract 778

otherwise provides for termination without cause. 779

~~(F)~~(G)(1) Disputes among parties to a health care contract 780
that only concern the enforcement of the contract rights 781
conferred by this section~~3963.02~~, divisions (A) and (D) of 782
section 3963.03, and section 3963.04 of the Revised Code are 783
subject to a mutually agreed upon arbitration mechanism that is 784
binding on all parties. The arbitrator may award reasonable 785
attorney's fees and costs for arbitration relating to the 786
enforcement of this section to the prevailing party. 787

(2) The arbitrator shall make the arbitrator's decision in 788
an arbitration proceeding having due regard for any applicable 789
rules, bulletins, rulings, or decisions issued by the department 790
of insurance or any court concerning the enforcement of the 791
contract rights conferred by this section~~3963.02~~, divisions (A) 792
and (D) of section 3963.03, and section 3963.04 of the Revised 793
Code. 794

(3) A party shall not simultaneously maintain an 795
arbitration proceeding as described in division ~~(F)~~(G)(1) of 796
this section and pursue a complaint with the superintendent of 797
insurance to investigate the subject matter of the arbitration 798
proceeding. However, if a complaint is filed with the department 799
of insurance, the superintendent may choose to investigate the 800
complaint or, after reviewing the complaint, advise the 801
complainant to proceed with arbitration to resolve the 802
complaint. The superintendent may request to receive a copy of 803
the results of the arbitration. If the superintendent of 804
insurance notifies an insurer or a health insuring corporation 805
in writing that the superintendent has initiated a market 806
conduct examination into the specific subject matter of the 807
arbitration proceeding pending against that insurer or health 808

insuring corporation, the arbitration proceeding shall be stayed 809
at the request of the insurer or health insuring corporation 810
pending the outcome of the market conduct investigation by the 811
superintendent. 812

Sec. 3963.03. (A) Each health care contract shall include 813
all of the following information: 814

(1) (a) Information sufficient for the participating 815
provider to determine the compensation or payment terms for 816
health care services, including all of the following, subject to 817
division (A) (1) (b) of this section: 818

(i) The manner of payment, such as fee-for-service, 819
capitation, or risk; 820

(ii) The fee schedule of procedure codes reasonably 821
expected to be billed by a participating provider's specialty 822
for services provided pursuant to the health care contract and 823
the associated payment or compensation for each procedure code. 824
A fee schedule may be provided electronically. Upon request, a 825
contracting entity shall provide a participating provider with 826
the fee schedule for any other procedure codes requested and a 827
written fee schedule, that shall not be required more frequently 828
than twice per year excluding when it is provided in connection 829
with any change to the schedule. This requirement may be 830
satisfied by providing a clearly understandable, readily 831
available mechanism, such as a specific web site address, that 832
allows a participating provider to determine the effect of 833
procedure codes on payment or compensation before a service is 834
provided or a claim is submitted. 835

(iii) The effect, if any, on payment or compensation if 836
more than one procedure code applies to the service also shall 837

be stated. This requirement may be satisfied by providing a 838
clearly understandable, readily available mechanism, such as a 839
specific web site address, that allows a participating provider 840
to determine the effect of procedure codes on payment or 841
compensation before a service is provided or a claim is 842
submitted. 843

(b) If the contracting entity is unable to include the 844
information described in ~~division~~ divisions (A) (1) (a) (ii) and 845
(iii) of this section, the contracting entity shall include both 846
of the following types of information instead: 847

(i) The methodology used to calculate any fee schedule, 848
such as relative value unit system and conversion factor or 849
percentage of billed charges. If applicable, the methodology 850
disclosure shall include the name of any relative value unit 851
system, its version, edition, or publication date, any 852
applicable conversion or geographic factor, and any date by 853
which compensation or fee schedules may be changed by the 854
methodology as anticipated at the time of contract. 855

(ii) The identity of any internal processing edits, 856
including the publisher, product name, version, and version 857
update of any editing software. 858

(c) If the contracting entity is not the payer and is 859
unable to include the information described in division (A) (1) 860
(a) or (b) of this section, then the contracting entity shall 861
provide by telephone a readily available mechanism, such as a 862
specific web site address, that allows the participating 863
provider to obtain that information from the payer. 864

(2) Any product or network for which the participating 865
provider is to provide services; 866

(3) The term of the health care contract;	867
(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment;	868 869 870 871
(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.	872 873 874 875 876 877 878 879
(6) A list of addenda, if any, to the contract.	880
(B) (1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers.	881 882 883 884 885 886 887 888
(2) The summary disclosure form shall include all of the following statements:	889 890
(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties;	891 892 893
(b) That reading the form is not a substitute for reading the entire health care contract;	894 895

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form:

"SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment

[] Fee for service

[] Capitation

[] Risk

[] Other	See	923	
(b) Fee schedule available at		924	
(c) Fee calculation schedule available at		925	
(d) Identity of internal processing edits available at		926 927	
(e) Information in (c) and (d) is not required if information in (b) is provided.		928 929	
(2) List of products or networks covered by this contract		930	
[]		931	
[]		932	
[]		933	
[]		934	
[]		935	
(3) Term of this contract		936	
(4) Contracting entity or payer responsible for processing payment available at		937 938	
(5) Internal mechanism for resolving disputes regarding contract terms available at		939 940	
(6) Addenda to contract		941	
	Title	Subject	942
(a)			943
(b)			944
(c)			945
(d)			946

(7) Telephone number to access a readily available 947
mechanism, such as a specific web site address, to allow a 948
participating provider to receive the information in (1) through 949
(6) from the payer. 950

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 951

The information provided in this Summary Disclosure Form 952
is a guide to the attached Health Care Contract as defined in 953
section ~~3963.01(G)~~3963.01(I) of the Ohio Revised Code. The 954
terms and conditions of the attached Health Care Contract 955
constitute the contract rights of the parties. 956

Reading this Summary Disclosure Form is not a substitute 957
for reading the entire Health Care Contract. When you sign the 958
Health Care Contract, you will be bound by its terms and 959
conditions. These terms and conditions may be amended over time 960
pursuant to section 3963.04 of the Ohio Revised Code. You are 961
encouraged to read any proposed amendments that are sent to you 962
after execution of the Health Care Contract. 963

Nothing in this Summary Disclosure Form creates any 964
additional rights or causes of action in favor of either party." 965

(C) When a contracting entity presents a proposed health 966
care contract for consideration by a provider, the contracting 967
entity shall provide in writing or make reasonably available the 968
information required in division (A)(1) of this section. 969

(D) The contracting entity shall identify any utilization 970
management, quality improvement, or a similar program that the 971
contracting entity uses to review, monitor, evaluate, or assess 972
the services provided pursuant to a health care contract. The 973
contracting entity shall disclose the policies, procedures, or 974
guidelines of such a program applicable to a participating 975

provider upon request by the participating provider within 976
fourteen days after the date of the request. 977

(E) Nothing in this section shall be construed as 978
preventing or affecting the application of section 1753.07 of 979
the Revised Code that would otherwise apply to a contract with a 980
participating provider. 981

(F) The requirements of division (C) of this section do 982
not prohibit a contracting entity from requiring a reasonable 983
confidentiality agreement between the provider and the 984
contracting entity regarding the terms of the proposed health 985
care contract. If either party violates the confidentiality 986
agreement, a party to the confidentiality agreement may bring a 987
civil action to enjoin the other party from continuing any act 988
that is in violation of the confidentiality agreement, to 989
recover damages, to terminate the contract, or to obtain any 990
combination of relief. 991

Section 2. That existing sections 1753.09, 3901.21, 992
3963.01, 3963.02, and 3963.03 of the Revised Code are hereby 993
repealed. 994

Section 3. The following represent the General Assembly's 995
intent and findings: 996

(A) The provisions of this act seek to prevent dental 997
insurers, dental benefit plans, and other contracting entities 998
from establishing fee limitations on services that are not 999
covered dental services for enrollees under a dental insurance 1000
plan. 1001

(B) Strategies by dental insurers, dental benefit plans, 1002
or other contracting entities to adopt or impose a deductible, 1003
copayment, coinsurance, or any other requirement in such a way 1004

as to provide de minimus reimbursement for services as a method	1005
to avoid the impact of this law is contrary to the spirit and	1006
intent of the General Assembly.	1007