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Senator Bacon

Cosponsors: Senators Hottinger, Tavares, Brown, Burke, Coley, Eklund, Hughes, Oelslager, Patton, Sawyer, Seitz Representatives Hackett, Bishoff, Anielski, Blessing, Buchy, Burkley, Green, Grossman, Henne, O'Brien, S., Rogers, Schaffer, Sears, Smith, R., Stinziano, Terhar

A BILL

To amend sections 3901.381, 3956.01, and 3956.04, 1
to enact new section 3907.12, and to repeal 2
section 3907.12 of the Revised Code to make 3
changes to the health coverage benefit limits 4
and coverage exclusions for life and health 5
insurance guaranty associations, to amend the 6
law relating to reinsurance contracts, to update 7
prompt payment requirements, to make changes to 8
the effective date of a provision relating to 9
subrogation, and to declare an emergency. 10

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

Section 1. That sections 3901.381, 3956.01, and 3956.04 be 11
amended and new section 3907.12 of the Revised Code be enacted 12
to read as follows: 13

Sec. 3901.381. (A) Except as provided in sections 14
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, 15
a third-party payer shall process a claim for payment for health 16

care services rendered by a provider to a beneficiary in 17
accordance with this section. 18

(B) (1) Unless division (B) (2) or (3) of this section 19
applies, when a third-party payer receives from a provider or 20
beneficiary a claim on the standard claim form prescribed in 21
rules adopted by the superintendent of insurance under section 22
3902.22 of the Revised Code, the third-party payer shall pay or 23
deny the claim not later than thirty days after receipt of the 24
claim. When a third-party payer denies a claim, the third-party 25
payer shall notify the provider and the beneficiary. The notice 26
shall state, with specificity, why the third-party payer denied 27
the claim. 28

(2) (a) Unless division (B) (3) of this section applies, 29
when a provider or beneficiary has used the standard claim form, 30
but the third-party payer determines that reasonable supporting 31
documentation is needed to establish the third-party payer's 32
responsibility to make payment, the third-party payer shall pay 33
or deny the claim not later than forty-five days after receipt 34
of the claim. Supporting documentation includes the verification 35
of employer and beneficiary coverage under a benefits contract, 36
confirmation of premium payment, medical information regarding 37
the beneficiary and the services provided, information on the 38
responsibility of another third-party payer to make payment or 39
confirmation of the amount of payment by another third-party 40
payer, and information that is needed to correct material 41
deficiencies in the claim related to a diagnosis or treatment or 42
the provider's identification. 43

Not later than thirty days after receipt of the claim, the 44
third-party payer shall notify all relevant external sources 45
that the supporting documentation is needed. All such notices 46

shall state, with specificity, the supporting documentation 47
needed. If the notice was not provided in writing, the provider, 48
beneficiary, or third-party payer may request the third-party 49
payer to provide the notice in writing, and the third-party 50
payer shall then provide the notice in writing. If any of the 51
supporting documentation is under the control of the 52
beneficiary, the beneficiary shall provide the supporting 53
documentation to the third-party payer. 54

The number of days that elapse between the third-party 55
payer's last request for supporting documentation within the 56
thirty-day period and the third-party payer's receipt of all of 57
the supporting documentation that was requested shall not be 58
counted for purposes of determining the third-party payer's 59
compliance with the time period of not more than forty-five days 60
for payment or denial of a claim. Except as provided in division 61
(B) (2) (b) of this section, if the third-party payer requests 62
additional supporting documentation after receiving the 63
initially requested documentation, the number of days that 64
elapse between making the request and receiving the additional 65
supporting documentation shall be counted for purposes of 66
determining the third-party payer's compliance with the time 67
period of not more than forty-five days. 68

(b) If a third-party payer determines, after receiving 69
initially requested documentation, that it needs additional 70
supporting documentation pertaining to a beneficiary's 71
preexisting condition, which condition was unknown to the third- 72
party payer and about which it was reasonable for the third- 73
party payer to have no knowledge at the time of its initial 74
request for documentation, and the third-party payer 75
subsequently requests this additional supporting documentation, 76
the number of days that elapse between making the request and 77

receiving the additional supporting documentation shall not be 78
counted for purposes of determining the third-party payer's 79
compliance with the time period of not more than forty-five 80
days. 81

(c) When a third-party payer denies a claim, the third- 82
party payer shall notify the provider and the beneficiary. The 83
notice shall state, with specificity, why the third-party payer 84
denied the claim. 85

(d) If a third-party payer determines that supporting 86
documentation related to medical information is routinely 87
necessary to process a claim for payment of a particular health 88
care service, the third-party payer shall establish a 89
description of the supporting documentation that is routinely 90
necessary and make the description available to providers in a 91
readily accessible format. 92

Third-party payers and providers shall, in connection with 93
a claim, use the most current CPT code in effect, as published 94
by the American medical association, the most current ICD-~~9~~10 95
code in effect, as published by the United States department of 96
health and human services, the most current CDT code in effect, 97
as published by the American dental association, or the most 98
current HCPCS code in effect, as published by the United States 99
health care financing administration. 100

(3) When a provider or beneficiary submits a claim by 101
using the standard claim form prescribed in the superintendent's 102
rules, but the information provided in the claim is materially 103
deficient, the third-party payer shall notify the provider or 104
beneficiary not later than fifteen days after receipt of the 105
claim. The notice shall state, with specificity, the information 106
needed to correct all material deficiencies. Once the material 107

deficiencies are corrected, the third-party payer shall proceed 108
in accordance with division (B) (1) or (2) of this section. 109

It is not a violation of the notification time period of 110
not more than fifteen days if a third-party payer fails to 111
notify a provider or beneficiary of material deficiencies in the 112
claim related to a diagnosis or treatment or the provider's 113
identification. A third-party payer may request the information 114
necessary to correct these deficiencies after the end of the 115
notification time period. Requests for such information shall be 116
made as requests for supporting documentation under division (B) 117
(2) of this section, and payment or denial of the claim is 118
subject to the time periods specified in that division. 119

(C) For purposes of this section, if a dispute exists 120
between a provider and a third-party payer as to the day a claim 121
form was received by the third-party payer, both of the 122
following apply: 123

(1) If the provider or a person acting on behalf of the 124
provider submits a claim directly to a third-party payer by mail 125
and retains a record of the day the claim was mailed, there 126
exists a rebuttable presumption that the claim was received by 127
the third-party payer on the fifth business day after the day 128
the claim was mailed, unless it can be proven otherwise. 129

(2) If the provider or a person acting on behalf of the 130
provider submits a claim directly to a third-party payer 131
electronically, there exists a rebuttable presumption that the 132
claim was received by the third-party payer twenty-four hours 133
after the claim was submitted, unless it can be proven 134
otherwise. 135

(D) Nothing in this section requires a third-party payer 136

to provide more than one notice to an employer whose premium for 137
coverage of employees under a benefits contract has not been 138
received by the third-party payer. 139

(E) Compliance with the provisions of division (B) (3) of 140
this section shall be determined separately from compliance with 141
the provisions of divisions (B) (1) and (2) of this section. 142

(F) A third party payer shall transmit electronically any 143
payment with respect to claims that the third party payer 144
receives electronically and pays to a contracted provider under 145
this section and under sections 3901.383, 3901.384, and 3901.386 146
of the Revised Code. A provider shall not refuse to accept a 147
payment made under this section or sections 3901.383, 3901.384, 148
and 3901.386 of the Revised Code on the basis that the payment 149
was transmitted electronically. 150

Sec. 3907.12. (A) As used in this section: 151

(1) "Assumption reinsurance" means the transfer of an 152
insurance contract from a domestic life insurance company to a 153
life insurance company authorized to do business in this state. 154

(2) "Individual risk" includes any policy, annuity, or 155
contract issued pursuant to section 3907.15 of the Revised Code. 156

(B) Except as provided in division (C) of this section, a 157
domestic life insurance company shall not reinsure, by agreement 158
or modification to an existing agreement, either of the 159
following without the prior approval of the superintendent of 160
insurance: 161

(1) More than eighty per cent of an individual risk to a 162
company authorized to transact the business of insurance in this 163
state; 164

(2) Any part of an individual risk to a company that is 165
not authorized to transact the business of insurance in this 166
state. 167

(C) Division (B) of this section shall not apply to either 168
of the following: 169

(1) Reinsurance agreements or modifications thereto in 170
which either of the following applies: 171

(a) The reinsurance premium or the change in the domestic 172
life insurance company's liabilities is less than five per cent 173
of the domestic life insurance company's surplus as regards 174
policy holders as of the thirty-first day of December next 175
preceding. 176

(b) The projected reinsurance premium or projected change 177
in the domestic life insurance company's liabilities in any of 178
the next three years is less than five per cent of the domestic 179
life insurance company's surplus as regards policyholders as of 180
the thirty-first day of December next preceding. 181

(2) Reinsurance agreements, or modifications to an 182
agreement, as the result of a facultative provision with an 183
authorized reinsurer. 184

(D) Any domestic life insurance company may, with the 185
written consent of the superintendent, enter into a contract of 186
reinsurance by which all of the domestic life insurance 187
company's obligations or risks, or the obligations or risks of a 188
product line or subset thereof, for in-force policies are 189
assumed by another life insurance company with the intent of 190
effecting a novation, commonly referred to as assumption 191
reinsurance. 192

Sec. 3956.01. As used in this chapter: 193

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.	194 195
(B) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion of the policy or contract, for which coverage is provided under section 3956.04 of the Revised Code.	196 197 198 199
(C) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.	200 201 202
(D) "Impaired insurer" means a member insurer that, after November 20, 1989, is not an insolvent insurer, and to which either of the following applies:	203 204 205
(1) The insurer is considered by the superintendent to be potentially unable to fulfill its contractual obligations;	206 207
(2) The insurer is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.	208 209
(E) "Insolvent insurer" means a member insurer that, after November 20, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.	210 211 212
(F) (1) "Member insurer" means any insurer that holds a certificate of authority or is licensed to transact in this state any kind of insurance for which coverage is provided under section 3956.04 of the Revised Code, and includes any insurer whose certificate of authority or license in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn after November 20, 1989.	213 214 215 216 217 218 219
(2) "Member insurer" does not include any of the following:	220 221

(a) A health insuring corporation;	222
(b) A fraternal benefit society;	223
(c) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;	224 225
(d) A mutual protective association;	226
(e) An insurance exchange;	227
(f) Any person who qualifies as a "member insurer" under section 3955.01 of the Revised Code and who does not receive premiums on covered policies or contracts;	228 229 230
(g) Any entity similar to any of those described in divisions (F) (2) (a) to (f) of this section.	231 232
(3) "Member insurer" includes any insurer that operates any of the entities described in division (F) (2) of this section as a line of business, and not as a separate, affiliated legal entity, and otherwise qualifies as a member insurer.	233 234 235 236
(G) "Premiums" means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned on the policies or contracts, and less dividends and experience credits on the policies and contracts. "Premiums" does not include either of the following:	237 238 239 240 241
(1) Any amounts in excess of one million dollars received on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended;	242 243 244 245 246
(2) Any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage	247 248

is not provided under section 3956.04 of the Revised Code. 249
Division (G) (2) of this section shall not be construed to 250
require the exclusion, from assessable premiums, of premiums 251
paid for coverages in excess of the interest limitations 252
specified in division (B) (2) (c) of section 3956.04 of the 253
Revised Code or of premiums paid for coverages in excess of the 254
limitations with respect to any one individual, any one 255
participant, or any one contract holder specified in division 256
(C) (2) of section 3956.04 of the Revised Code. 257

(H) "Resident" means any person who resides in this state 258
at the time a member insurer is determined to be an impaired or 259
insolvent insurer and to whom a contractual obligation is owed. 260
A person may be a resident of only one state, which, in the case 261
of a person other than a natural person, shall be its principal 262
place of business. Citizens of the United States who are either 263
residents of a foreign country or residents of a United States 264
possession, territory, or protectorate that does not have an 265
association similar to the association created by this chapter 266
shall be considered residents of the state of domicile of the 267
insurer that issued the policy or contract. 268

(I) "Structured settlement annuity" means an annuity 269
purchased in order to fund periodic payments for a plaintiff or 270
other claimant in payment for or with respect to personal injury 271
suffered by the plaintiff or other claimant. 272

(J) "Subaccount" means any of the three subaccounts 273
created under division (A) of section 3956.06 of the Revised 274
Code. 275

~~(J)~~ (K) "Supplemental contract" means any agreement 276
entered into for the distribution of policy or contract 277
proceeds. 278

~~(K)~~-(L) "Unallocated annuity contract" means any annuity 279
contract or group annuity certificate that is not issued to and 280
owned by an individual, except to the extent of any annuity 281
benefits guaranteed to an individual by an insurer under that 282
contract or certificate. 283

Sec. 3956.04. (A) This chapter provides coverage, by the 284
Ohio life and health insurance guaranty association, for the 285
policies and contracts specified in division (B) of this section 286
to all of the following persons: 287

(1) Persons who are the beneficiaries, assignees, or 288
payees of the persons covered under division (A) (2) of this 289
section, regardless of where they reside, except for nonresident 290
certificate holders under group policies or contracts; 291

(2) Persons who are owners of or certificate holders under 292
the policies or contracts other than structured settlement 293
annuities, or, in the case of unallocated annuity contracts, the 294
persons who are the contract holders, if either of the following 295
applies: 296

(a) The persons are residents of this state; 297

(b) The persons are not residents of this state and all of 298
the following conditions apply: 299

(i) The insurers that issued the policies or contracts are 300
domiciled in this state; 301

(ii) At the time the policies or contracts were issued, 302
the insurers did not hold a license or certificate of authority 303
in the states in which the persons reside; 304

(iii) The states have associations similar to the 305
association created by section 3956.06 of the Revised Code; 306

(iv) The persons are not eligible for coverage by those associations. 307
308

(3) Persons who are payees, or the beneficiary of a payee 309
if the payee is deceased, under a structured settlement annuity 310
if the payee is a resident of this state, regardless of where 311
the contract owner resides; 312

(4) Persons who are payees, or the beneficiary of a payee 313
if the payee is deceased, under a structured settlement annuity 314
if the payee is not a resident of this state, but both of the 315
following are true: 316

(a) The contract owner of the structured settlement 317
annuity is a resident of this state or, if the contract owner of 318
the structured settlement annuity is not a resident of this 319
state, the insurer that issued the structured settlement annuity 320
is domiciled in this state and the state in which the contract 321
owner resides has an association similar to the association 322
created by this chapter. 323

(b) The payee, the beneficiary, and the contract owner are 324
not eligible for coverage by the association of the state in 325
which the payee or contract owner resides. 326

(5) Persons who are payees or beneficiaries of a contract 327
owner resident of this state to the extent coverage is provided 328
under division (A) (4) of this section, unless the payee or 329
beneficiary is afforded any coverage by the association of 330
another state. 331

This chapter is intended to provide coverage to a person 332
who is a resident of this state and, in special circumstances, 333
to a nonresident. To avoid duplicate coverage, if a person who 334
would otherwise receive coverage under this chapter receives 335

coverage under the laws of another state, the person shall not 336
be provided coverage under this chapter. In determining the 337
application of the provisions of this chapter in situations in 338
which a person could be covered by the association of more than 339
one state, whether as an owner, payee, beneficiary, or assignee, 340
this chapter shall be construed in conjunction with other state 341
laws to result in coverage by only one association. 342

(B) (1) This chapter provides coverage to the persons 343
specified in division (A) of this section for direct, nongroup 344
life, health, or annuity, ~~and supplemental~~ policies or 345
contracts, for certificates under direct group policies and 346
contracts, for supplemental contracts to any of the preceding, 347
and for unallocated annuity contracts, in each case issued by 348
member insurers, except as otherwise limited in this chapter. 349
Annuity contracts and certificates under group annuity contracts 350
include, but are not limited to, guaranteed investment 351
contracts, deposit administration contracts, unallocated funding 352
agreements, allocated funding agreements, structured settlement 353
~~agreements, lottery contracts~~ annuities, annuities issued to or 354
in connection with government lotteries, and any immediate or 355
deferred annuity contracts. 356

(2) This chapter does not provide coverage for any of the 357
following: 358

(a) Any portion of a policy or contract not guaranteed by 359
the insurer, or under which the risk is borne by the policy or 360
contract holder; 361

(b) Any policy or contract of reinsurance, unless 362
assumption certificates have been issued; 363

(c) Any portion of a policy or contract to the extent that 364

the rate of interest on which it is based: 365

(i) Averaged over the period of four years prior to the 366
date on which the association becomes obligated with respect to 367
the policy or contract or if the policy or contract has been 368
issued for a lesser period averaged over that period, exceeds 369
the rate of interest determined by subtracting two percentage 370
points from the monthly average-corporates as published by 371
Moody's investors service, inc., or any successor to that 372
service, averaged for the same period; 373

(ii) On and after the date on which the association 374
becomes obligated with respect to the policy or contract, 375
exceeds the rate of interest determined by subtracting three 376
percentage points from the monthly average-corporates as 377
published by Moody's investors service, inc., or any successor 378
to that service, as most recently available. 379

If the monthly average-corporates is no longer published, 380
the superintendent, by rule, shall establish a substantially 381
similar average. 382

(d) Any plan or program of an employer, association, or 383
similar entity to provide life, health, or annuity benefits to 384
its employees or members to the extent that the plan or program 385
is self-funded or uninsured, including but not limited to 386
benefits payable by an employer, association, or similar entity 387
under any of the following: 388

(i) A multiple employer welfare arrangement as defined in 389
section ~~514-3(40)~~ of the "Employee Retirement Income Security 390
Act of 1974," 88 Stat. 833, 29 U.S.C.A. ~~1001~~1002(40), as 391
amended; 392

(ii) A minimum premium group insurance plan; 393

(iii) A stop-loss group insurance plan;	394
(iv) An administrative services only contract.	395
(e) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;	396 397 398 399 400
(f) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;	401 402 403 404
(g) Any unallocated annuity contract issued to an employee benefit plan protected under the federal pension benefit guaranty corporation;	405 406 407
(h) Any portion of any unallocated annuity contract that is not issued to or in connection with a governmental lottery or a benefit plan of a specific employee, union, or association of natural persons;	408 409 410 411
(i) Any policy or contract issued to or for the benefit of a past or present director or officer within one year of the filing of the successful complaint that the insurer was impaired or insolvent;	412 413 414 415
(j) Any policy or contract issued by any entity described in division (F) (2) of section 3956.01 of the Revised Code;	416 417
(k) Any policy or contract issued by a member insurer if the member insurer is carrying on as a line of business, and not as a separate legal entity, the activities of any entity described in division (F) (2) of section 3956.01 of the Revised	418 419 420 421

Code, and the policy or contract is issued as a product of those activities;

(1) Any policy or contract providing hospital, medical, prescription drug, or other health care benefits pursuant to 42 U.S.C. Chapter 7, Title XVIII, Parts C and D and any corresponding regulations.

(C) The benefits for which the association may become liable shall not exceed the lesser of either of the following:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(2) (a) With respect to any one life, regardless of the number of policies or contracts:

(i) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(ii) One hundred thousand dollars in health insurance benefits other than basic hospital, medical, and surgical insurance, major medical insurance, disability insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(iii) Three hundred thousand dollars in disability insurance;

(iv) Three hundred thousand dollars in long-term care insurance;

(v) Five hundred thousand dollars in basic hospital, medical, and surgical insurance or major medical insurance;

(vi) Two hundred fifty thousand dollars in the present 450
value of annuity benefits, including net cash surrender and net 451
cash withdrawal values. 452

(b) With respect to each individual participating in a 453
governmental retirement plan established under section 401, 454
403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 455
2085, 26 U.S.C.A. 1, as amended, and covered by an unallocated 456
annuity contract, or the beneficiaries of each such individual 457
if deceased, in the aggregate, two hundred fifty thousand 458
dollars in present value annuity benefits, including net cash 459
surrender and net cash withdrawal values. 460

The association is not liable to expend more than three 461
hundred thousand dollars in the aggregate with respect to any 462
one individual under divisions (C) (2) (a) ~~and~~, (b), and (d) of 463
this section combined, except with respect to benefits for basic 464
hospital, medical, and surgical insurance and major medical 465
insurance under division (C) (2) (a) (v) of this section, in which 466
case the aggregate liability of the association shall not exceed 467
five hundred thousand dollars with respect to any one 468
individual. 469

(c) With respect to any one contract holder, covered by 470
any unallocated annuity contract not included in division (C) (2) 471
(b) of this section, one million dollars in benefits, 472
irrespective of the number of those contracts held by that 473
contract holder. 474

(d) With respect to each payee of a structured settlement 475
annuity, or the beneficiary or beneficiaries of the payee if the 476
payee is deceased, two hundred fifty thousand dollars in present 477
value of annuity benefits, in the aggregate, including net cash 478
surrender and net cash withdrawal values, if any. 479

(D) The liability of the association is limited strictly 480
by the express terms of the policies or contracts and by this 481
chapter, and is not affected by the contents of any brochures, 482
illustrations, advertisements in the print or electronic media, 483
or other advertising material used in connection with the sale 484
of the policies or contracts, or by oral statements made by 485
agents or other sales representatives in connection with the 486
sale of the policies or contracts. The association is not liable 487
for extra-contractual damages, punitive damages, attorney's 488
fees, or interest other than as provided for by the terms of the 489
policies or contracts as limited by this chapter, that might be 490
awarded by any court or governmental agency in connection with 491
the policies or contracts. 492

(E) The protection provided by this chapter does not apply 493
where any guaranty protection is provided to residents of this 494
state by the laws of the domiciliary state or jurisdiction of 495
the impaired or insolvent insurer other than this state. 496

Section 2. That existing sections 3901.381, 3956.01, and 497
3956.04 and section 3907.12 of the Revised Code are hereby 498
repealed. 499

Section 3. Section 2323.44 of the Revised Code shall not 500
apply to multiple employer welfare arrangements, health insuring 501
corporations, or sickness and accident insurers authorized to do 502
business in this state under Title XVII or XXXIX of the Revised 503
Code with respect to any policy, contract, or agreement that is 504
delivered, issued for delivery, or renewed on or after the 505
effective date of this section through December 31, 2016. 506
Multiple employer welfare arrangements, health insuring 507
corporations, or sickness and accident insurers authorized to do 508
business in this state under Title XVII or XXXIX of the Revised 509

Code shall be subject to section 2323.44 of the Revised Code 510
with respect to any policy, contract, or agreement that is 511
delivered, issued for delivery, or renewed on or after January 512
1, 2017. 513

Section 4. This act is hereby declared to be an emergency 514
measure necessary for the immediate preservation of the public 515
peace, health, and safety. The reason for such necessity is that 516
those amendments are necessary to protect insurance consumers in 517
this state who would be affected by pending action that may 518
result in an insurer doing business in this state being found 519
insolvent and ordered into liquidation. Therefore, this act 520
shall go into immediate effect. 521

Section 5. Section 4 of this act applies only to Section 3 522
of this act and the amendment of sections 3956.01 and 3956.04 of 523
the Revised Code by this act. 524