(131st General Assembly)
(Substitute Senate Bill Number 223)

AN ACT

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

Be it enacted by the General Assembly of the State of Ohio:

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

Sec. 3901.381. (A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

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

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

Not later than thirty days after receipt of the claim, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting

documentation to the third-party payer.

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

(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

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

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

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

(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.

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

that division.

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

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

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

(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 3956.01. As used in this chapter:

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.

(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.

(C) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.

(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:~~

~~(1) The insurer is considered by the superintendent to be potentially unable to fulfill its contractual obligations;~~

~~(2) The insurer~~ is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(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.

(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.

(2) "Member insurer" does not include any of the following:

(a) A health insuring corporation;

(b) A fraternal benefit society;

(c) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;

(d) A mutual protective association;

(e) An insurance exchange;

(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;

(g) Any entity similar to any of those described in divisions (F)(2)(a) to (f) of this section.

(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.

(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:

(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;

(2) Any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 3956.04 of the Revised Code. Division (G)(2) of this section shall not be construed to require the exclusion, from assessable premiums, of premiums paid for coverages in excess of the interest limitations specified in division (B)(2)(c) of section 3956.04 of the Revised Code or of premiums paid for coverages in excess of the limitations with respect to any one individual, any one participant, or any one contract holder specified in division (C)(2) of section 3956.04 of the Revised Code.

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

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

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

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

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

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

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

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

(a) The persons are residents of this state;

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

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

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

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

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

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

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

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

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

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

This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter receives coverage under the laws of another state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this chapter in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

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

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

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

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

(c) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract or if the policy or contract has been issued for a lesser

period averaged over that period, exceeds the rate of interest determined by subtracting two percentage points from the monthly average-corporates as published by Moody's investors service, inc., or any successor to that service, averaged for the same period;

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

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

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

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

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan;

(iv) An administrative services only contract.

(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;

(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;

(g) Any unallocated annuity contract issued to an employee benefit plan protected under the federal pension benefit guaranty corporation;

(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;

(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;

(j) Any policy or contract issued by any entity described in division (F)(2) of section 3956.01 of the Revised Code;

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

(l) 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 value of annuity benefits, including net cash surrender and net cash withdrawal values.

(b) With respect to each individual participating in 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, and covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values.

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

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

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

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

(E) The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired

or insolvent insurer other than this state.

SECTION 2. That existing sections 3901.381, 3956.01, and 3956.04 and section 3907.12 of the Revised Code are hereby repealed.

SECTION 3. Section 2323.44 of the Revised Code shall not apply to multiple employer welfare arrangements, health insuring corporations, or sickness and accident insurers authorized to do business in this state under Title XVII or XXXIX of the Revised Code with respect to any policy, contract, or agreement that is delivered, issued for delivery, or renewed on or after the effective date of this section through December 31, 2016. Multiple employer welfare arrangements, health insuring corporations, or sickness and accident insurers authorized to do business in this state under Title XVII or XXXIX of the Revised Code shall be subject to section 2323.44 of the Revised Code with respect to any policy, contract, or agreement that is delivered, issued for delivery, or renewed on or after January 1, 2017.

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

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

Speaker _____ of the House of Representatives.

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

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Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____