

**As Introduced**

**133rd General Assembly**

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**H. B. No. 390**

**Representatives Crossman, Clites**

**Cosponsors: Representatives Sweeney, Leland, Sobecki, Robinson, Galonski, Brent, Hicks-Hudson, Denson, Blair, Weinstein, Liston, Smith, K., Patterson, Miranda, Lightbody, Boyd, Skindell, Russo, Kelly, West, Brown, Upchurch, Crawley, Miller, J., Sheehy, Lepore-Hagan, Strahorn, Sykes, O'Brien, Howse, Boggs, Rogers, Ingram, Miller, A., Cera, Hillyer, Carfagna**

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**A BILL**

To amend sections 1731.03, 1731.04, 1731.05, 1  
1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 2  
1751.16, 1751.18, 1751.58, 1751.69, 3922.01, 3  
3923.122, 3923.57, 3923.571, 3923.85, 3924.01, 4  
3924.02, 3924.03, 3924.033, 3924.06, 3924.51, 5  
and 3924.73, to enact sections 3902.50, 3902.51, 6  
3902.52, 3902.53, and 3902.54, and to repeal 7  
sections 1751.15, 3923.58, 3923.581, 3923.582, 8  
3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 9  
3924.11, 3924.111, 3924.12, 3924.13, and 3924.14 10  
of the Revised Code regarding health insurance 11  
premiums and benefits. 12

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

**Section 1.** That sections 1731.03, 1731.04, 1731.05, 13  
1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 1751.18, 14  
1751.58, 1751.69, 3922.01, 3923.122, 3923.57, 3923.571, 3923.85, 15  
3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 3924.51, and 16

3924.73 be amended and sections 3902.50, 3902.51, 3902.52, 17  
3902.53, and 3902.54 of the Revised Code be enacted to read as 18  
follows: 19

**Sec. 1731.03.** (A) A small employer health care alliance 20  
may do any of the following: 21

(1) Negotiate and enter into agreements with one or more 22  
insurers for the insurers to offer and provide one or more 23  
health benefit plans to small employers for their employees and 24  
retirees, and the dependents and members of the families of such 25  
employees and retirees, which coverage may be made available to 26  
enrolled small employers without regard to industrial, rating, 27  
or other classifications among the enrolled small employers 28  
under an alliance program, except as otherwise provided under 29  
the alliance program, and for the alliance to perform, or 30  
contract with others for the performance of, functions under or 31  
with respect to the alliance program; 32

(2) Contract with another alliance for the inclusion of 33  
the small employer members of one in the alliance program of the 34  
other; 35

(3) Provide or cause to be provided to small employers 36  
information concerning the availability, coverage, benefits, 37  
premiums, and other information regarding an alliance program 38  
and promote the alliance program; 39

(4) Provide, or contract with others to provide, 40  
enrollment, record keeping, information, premium billing, 41  
collection and transmittal, and other services under an alliance 42  
program; 43

(5) Receive reports and information from the insurer and 44  
negotiate and enter into agreements with respect to inspection 45

and audit of the books and records of the insurer; 46

(6) Provide services to and on behalf of an alliance 47  
program sponsored by another alliance, including entering into 48  
an agreement described in division (B) of section 1731.01 of the 49  
Revised Code on behalf of the other alliance; 50

(7) If it is a nonprofit corporation created under Chapter 51  
1702. of the Revised Code, exercise all powers and authority of 52  
such corporations under the laws of the state, or, if otherwise 53  
constituted, exercise such powers and authority as apply to it 54  
under the applicable laws, and its articles, regulations, 55  
constitution, bylaws, or other relevant governing instruments. 56

(B) A small employer health care alliance is not and shall 57  
not be regarded for any purpose of law as an insurer, an offeror 58  
or seller of any insurance, a partner of or joint venturer with 59  
any insurer, an agent of, or solicitor for an agent of, or 60  
representative of, an insurer or an offeror or seller of any 61  
insurance, an adjuster of claims, or a third-party 62  
administrator, and will not be liable under or by reason of any 63  
insurance coverage or other health benefit plan provided or not 64  
provided by any insurer or by reason of any conditions or 65  
restrictions on eligibility or benefits under an alliance 66  
program or any insurance or other health benefit plan provided 67  
under an alliance program or by reason of the application of 68  
those conditions or restrictions. 69

(C) The promotion of an alliance program by an alliance or 70  
by an insurer is not and shall not be regarded for any purpose 71  
of law as the offer, solicitation, or sale of insurance. 72

(D) (1) No alliance shall adopt, impose, or enforce medical 73  
underwriting rules or underwriting rules requiring a small 74

employer to have more than a minimum number of employees for the 75  
purpose of determining whether an alliance member is eligible to 76  
purchase a policy, contract, or plan of health insurance or 77  
health benefits from any insurer in connection with the alliance 78  
health care program. 79

(2) No alliance shall reject any applicant for membership 80  
in the alliance based on the health status of the applicant's 81  
employees or their dependents or because the small employer does 82  
not have more than a minimum number of employees. 83

(3) A violation of division (D)(1) or (2) of this section 84  
is deemed to be an unfair and deceptive act or practice in the 85  
business of insurance under sections 3901.19 to 3901.26 of the 86  
Revised Code. 87

(4) Nothing in division (D)(1) or (2) of this section 88  
shall be construed as inhibiting or preventing an alliance from 89  
adopting, imposing, and enforcing rules, conditions, 90  
limitations, or restrictions that are based on factors other 91  
than the health status of employees or their dependents or the 92  
size of the small employer for the purpose of determining 93  
whether a small employer is eligible to become a member of the 94  
alliance. Division (D)(1) of this section does not apply to an 95  
insurer that sells health coverage to an alliance member under 96  
an alliance health care program. 97

(E) Except as otherwise specified in section 1731.09 of 98  
the Revised Code, health benefit plans offered and sold to 99  
alliance members that are small employers as defined in section 100  
3924.01 of the Revised Code are subject to sections 3924.01 to 101  
~~3924.14~~ 3924.06 of the Revised Code. 102

(F) Any person who represents an alliance in bargaining or 103

negotiating a health benefit plan with an insurer shall disclose 104  
to the governing board of the alliance any direct or indirect 105  
financial relationship the person has or had during the past two 106  
years with the insurer. 107

**Sec. 1731.04.** (A) An agreement between an alliance and an 108  
insurer referred to in division (B) of section 1731.01 of the 109  
Revised Code shall contain at least the following: 110

(1) A provision requiring the insurer to offer and sell to 111  
small employers served or to be served by an alliance one or 112  
more health benefit plan options for coverage of their eligible 113  
employees and the eligible dependents and members of the 114  
families of the eligible employees and, if applicable, such 115  
members' eligible retirees and the eligible dependents and 116  
members of the families of the retirees, subject to such 117  
conditions and restrictions as may be set forth or incorporated 118  
into the agreement; 119

(2) A brief description of each type of health benefit 120  
plan option that is to be so offered and the conditions for the 121  
modification, continuation, and termination of the coverage and 122  
benefits thereunder; 123

(3) A statement of the eligibility requirements that an 124  
employee or retiree must meet in order for the employee or 125  
retiree to be eligible to obtain and retain coverage under any 126  
health benefit plan option so offered and, if one of such 127  
requirements is that an employee must regularly work for a 128  
minimum number of hours per week, a statement of such minimum 129  
number of hours, which minimum shall not exceed twenty-five 130  
hours per week; 131

~~(4) A description of any pre-existing condition and~~ 132

<del>waiting period rules;</del>	133
<del>(5)</del> —A statement of the premium rates or other charges that apply to each health benefit plan option or a formula or method of determining the rates or charges;	134 135 136
<del>(6)</del> — <u>(5)</u> A provision prescribing the minimum employer contribution toward premiums or other charges required in order to permit a small employer to obtain coverage under a health benefit plan option offered under an alliance program;	137 138 139 140
<del>(7)</del> — <u>(6)</u> A provision requiring that each health benefit plan under the alliance program must provide for the continuation of coverage of participants of an enrolled small employer so long as the small employer determines that such person is a qualified beneficiary entitled to such coverage pursuant to Part 6 of Title I of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, and the laws of this state, and regulations or rulings interpreting such provisions. Such coverage provided by the insurer under the plan to participants shall comply with the "Federal Employee Retirement Income Security Act of 1974" and the relevant statutes, regulations, and rulings interpreting that act, including provisions regarding types of coverage to be provided, apportionments of limitations on coverage, apportionments of deductibles, and the rights of qualified beneficiaries to elect coverage options relating to types of coverage and otherwise.	141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157
(B) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code may contain provisions relating to, but not limited to, any of the following:	158 159 160 161

(1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards;	162 163 164
(2) The minimum number of those employees eligible to be participants that are required to participate in order to permit a small employer to obtain coverage under a health benefit plan option offered under the alliance program, which may vary with the number of employees or those eligible to be participants in respect of the small employer;	165 166 167 168 169 170
(3) A procedure for allowing an enrolled small employer to change from one plan option to another under the alliance program, subject to qualifying by size or otherwise under the alliance program;	171 172 173 174
(4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer;	175 176 177
(5) The availability of a medicare supplement coverage option for eligible participants who are covered by Parts A and B of medicare, Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301;	178 179 180 181
(6) Relevant experience periods, enrollment periods, and contract periods;	182 183
(7) Effective dates for coverage of eligible participants;	184
(8) Conditions under which denial or withdrawal of coverage of participants or small employers and their employees may occur by reason of falsification or misrepresentation of material facts or criminal conduct toward the insurer, small employer, or alliance under the program;	185 186 187 188 189

(9) Premium rate structures, which may be uniform or make provision for age-specific rates, differentials based on number of participants of an enrolled small employer, products and plan options selected, and other factors, rate adjustments based on consumer price indices, utilization, or other relevant factors, notification of rate adjustments, and arbitration;	190 191 192 193 194 195
(10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums;	196 197
(11) Inclusion under the alliance program of small employers that are members of other organizations described in division (A) (1) of section 1731.01 of the Revised Code that contract with the alliance for this purpose, and conditions pertaining to those small employer members and to their employees and retirees, and dependents and family members of those employees or retirees, as applicable under the alliance program;	198 199 200 201 202 203 204 205
(12) The agreement of the insurer to offer and sell one or more health benefit plans to small employer members of another small employer health care alliance that contracts with the alliance for this purpose;	206 207 208 209
(13) Use of the health benefit plan options of the insurer in the alliance program and use of the names of the alliance and the insurer;	210 211 212
(14) Indemnification from claims and liability by reason of acts or omissions of others;	213 214
(15) Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program;	215 216 217
(16) Utilization reports to be provided to the alliance by	218

the insurer;	219
(17) Such other provisions as may be agreed upon by the alliance and the insurer to better provide for the articulation, promotion, financing, and operation of the alliance program or a health benefit plan under the program in furtherance of the public purposes stated in section 1731.02 of the Revised Code.	220 221 222 223 224
(C) Neither an alliance program nor an agreement between an alliance and an insurer is itself a policy or contract of insurance, or a certificate, indorsement, rider, or application forming any part of a policy, contract, or certificate of insurance. Chapters 3905., 3933., and 3959. of the Revised Code do not apply to an alliance program or to an agreement between an alliance and an insurer thereunder, as such, or to the functions of the alliance under an alliance program.	225 226 227 228 229 230 231 232
<b>Sec. 1731.05.</b> If a qualified alliance, or an alliance that, based upon evidence of interest satisfactory to the superintendent of insurance, will be a qualified alliance within a reasonable time, submits a request for a proposal on a health benefit plan to at least three insurers and does not receive at least one reasonably responsive proposal within ninety days from the date the last such request is submitted, the superintendent, at the request of such alliance, may require that insurers offer proposals to such alliance for health benefit plans for the small employers within such alliance. Such proposals shall include such coverage and benefits for such premiums, as shall take into account the functions provided by the alliance and the economies of scale, and have other terms and provisions as are approved by the superintendent, consistent with the purposes and standards set forth in section 1731.02 of the Revised Code. <del>In making the determination as to which insurers shall be asked to</del>	233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248

~~submit proposals under this section, the superintendent shall~~ 249  
~~apply the standards set forth in division (G) (4) (a) of section~~ 250  
~~3924.11 of the Revised Code.~~ Any insurer that does not submit a 251  
proposal when required to do so by the superintendent hereunder, 252  
shall be deemed to be in violation of section 3901.20 of the 253  
Revised Code and shall be subject to all of the provisions of 254  
section 3901.22 of the Revised Code, including division (D) (1) 255  
of section 3901.22 of the Revised Code as if it provided that 256  
the superintendent may suspend or revoke an insurer's license to 257  
engage in the business of insurance. 258

Nothing in this section shall be construed as requiring an 259  
insurer to enter into an agreement with an alliance under 260  
contractual terms that are not acceptable to the insurer or to 261  
authorize the superintendent to require an insurer to enter into 262  
an agreement with an alliance under contractual terms that are 263  
not acceptable to the insurer. 264

This section applies beginning eighteen months after its 265  
effective date. 266

**Sec. 1731.09.** (A) Nothing contained in this chapter is 267  
intended to or shall inhibit or prevent the application of the 268  
provisions of Chapter 3924. of the Revised Code to any health 269  
benefit plan or insurer to which they would otherwise apply in 270  
the absence of this chapter, except as otherwise specified in 271  
divisions (B) and (C) of this section or unless such application 272  
conflicts with the provisions of section 1731.05 of the Revised 273  
Code. 274

(B) An insurer may establish one or more separate classes 275  
of business solely comprised of one or more alliances. All of 276  
the following shall apply to health plans covering small 277  
employers in each class of business established pursuant to this 278

division:	279
(1) The premium rate limitations set forth in section	280
3924.04 of the Revised Code apply to each class of business	281
separate and apart from the insurer's other business;	282
(2) For purposes of applying sections 3924.01 to <del>3924.14</del>	283
<u>3924.06</u> of the Revised Code to a class of business, the base	284
premium rate and midpoint rate shall be determined with respect	285
to each class of business separate and apart from the insurer's	286
other business.	287
(3) The midpoint rate for a class of business shall not	288
exceed the midpoint rate for any other class of business or the	289
insurer's non-alliance business by more than fifteen per cent.	290
(4) The insurer annually shall file with the	291
superintendent of insurance an actuarial certification	292
consistent with section 3924.06 of the Revised Code for each	293
class of business demonstrating that the underwriting and rating	294
methods of the insurer do all of the following:	295
(a) Comply with accepted actuarial practices;	296
(b) Are uniformly applied to health benefit plans covering	297
small employers within the class of business;	298
(c) Comply with the applicable provisions of this section	299
and sections 3924.01 to <del>3924.14</del> <u>3924.06</u> of the Revised Code.	300
(5) An insurer shall apply sections 3924.01 to <del>3924.14</del>	301
<u>3924.06</u> of the Revised Code to the insurer's non-alliance	302
business and coverage sold through alliances not established as	303
a separate class of business.	304
(6) An insurer shall file with the superintendent a	305
notification identifying any alliance or alliances to be treated	306

as a separate class of business at least sixty days prior to the 307  
date the rates for that class of business take effect. 308

(7) Any application for a certificate of authority filed 309  
pursuant to section 1731.021 of the Revised Code shall include a 310  
disclosure as to whether the alliance will be underwritten or 311  
rated as part of a separate class of business. 312

(C) As used in this section: 313

(1) "Class of business" means a group of small employers, 314  
as defined in section 3924.01 of the Revised Code, that are 315  
enrolled employers in one or more alliances. 316

(2) "Actuarial certification," "base premium rate," and 317  
"midpoint rate" have the same meanings as in section 3924.01 of 318  
the Revised Code. 319

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 320  
that is created pursuant to sections 1739.01 to 1739.22 of the 321  
Revised Code and that operates a group self-insurance program 322  
may be established only if any of the following applies: 323

(1) The arrangement has and maintains a minimum enrollment 324  
of three hundred employees of two or more employers. 325

(2) The arrangement has and maintains a minimum enrollment 326  
of three hundred self-employed individuals. 327

(3) The arrangement has and maintains a minimum enrollment 328  
of three hundred employees or self-employed individuals in any 329  
combination of divisions (A) (1) and (2) of this section. 330

(B) A multiple employer welfare arrangement that is 331  
created pursuant to sections 1739.01 to 1739.22 of the Revised 332  
Code and that operates a group self-insurance program shall 333  
comply with all laws applicable to self-funded programs in this 334

state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 335  
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 336  
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 337  
3923.30, 3923.301, 3923.38, ~~3923.581~~, 3923.602, 3923.63, 338  
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.89, 3923.90, 339  
3924.031, 3924.032, and 3924.27 of the Revised Code. 340

(C) A multiple employer welfare arrangement created 341  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 342  
shall solicit enrollments only through agents or solicitors 343  
licensed pursuant to Chapter 3905. of the Revised Code to sell 344  
or solicit sickness and accident insurance. 345

(D) A multiple employer welfare arrangement created 346  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 347  
shall provide benefits only to individuals who are members, 348  
employees of members, or the dependents of members or employees, 349  
or are eligible for continuation of coverage under section 350  
1751.53 or 3923.38 of the Revised Code or under Title X of the 351  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 352  
Stat. 227, 29 U.S.C.A. 1161, as amended. 353

(E) A multiple employer welfare arrangement created 354  
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 355  
subject to, and shall comply with, sections 3903.81 to 3903.93 356  
of the Revised Code in the same manner as other life or health 357  
insurers, as defined in section 3903.81 of the Revised Code. 358

**Sec. 1751.01.** As used in this chapter: 359

(A) (1) "Basic health care services" means the following 360  
services when medically necessary and, except for health care 361  
plans offered in the large group market, the essential health 362  
benefits identified in division (B) (1) of section 3902.53 of the 363

<u>Revised Code:</u>	364
(a) Physician's services, except when such services are supplemental under division (B) of this section;	365 366
(b) Inpatient hospital services;	367
(c) Outpatient medical services;	368
(d) Emergency health services;	369
(e) Urgent care services;	370
(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;	371 372
(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;	373 374 375
(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;	376 377 378 379
(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.	380 381 382
"Basic health care services" does not include experimental procedures.	383 384
Except as provided by divisions (A) (2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all	385 386 387 388 389 390

listed basic health care services. However, this requirement 391  
does not apply to the coverage of beneficiaries enrolled in 392  
medicare pursuant to a medicare contract, or to the coverage of 393  
beneficiaries enrolled in the federal employee health benefits 394  
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 395  
medicaid recipients, or to the coverage of beneficiaries under 396  
any federal health care program regulated by a federal 397  
regulatory body, or to the coverage of beneficiaries under any 398  
contract covering officers or employees of the state that has 399  
been entered into by the department of administrative services. 400

(2) A health insuring corporation may offer coverage for 401  
diagnostic and treatment services for biologically based mental 402  
illnesses without offering coverage for all other basic health 403  
care services. A health insuring corporation may offer coverage 404  
for diagnostic and treatment services for biologically based 405  
mental illnesses alone or in combination with one or more 406  
supplemental health care services. However, a health insuring 407  
corporation that offers coverage for any other basic health care 408  
service shall offer coverage for diagnostic and treatment 409  
services for biologically based mental illnesses in combination 410  
with the offer of coverage for all other listed basic health 411  
care services. 412

(3) A health insuring corporation that offers coverage for 413  
basic health care services is not required to offer coverage for 414  
diagnostic and treatment services for biologically based mental 415  
illnesses in combination with the offer of coverage for all 416  
other listed basic health care services if all of the following 417  
apply: 418

(a) The health insuring corporation submits documentation 419  
certified by an independent member of the American academy of 420

actuaries to the superintendent of insurance showing that 421  
incurred claims for diagnostic and treatment services for 422  
biologically based mental illnesses for a period of at least six 423  
months independently caused the health insuring corporation's 424  
costs for claims and administrative expenses for the coverage of 425  
basic health care services to increase by more than one per cent 426  
per year. 427

(b) The health insuring corporation submits a signed 428  
letter from an independent member of the American academy of 429  
actuaries to the superintendent of insurance opining that the 430  
increase in costs described in division (A) (3) (a) of this 431  
section could reasonably justify an increase of more than one 432  
per cent in the annual premiums or rates charged by the health 433  
insuring corporation for the coverage of basic health care 434  
services. 435

(c) The superintendent of insurance makes the following 436  
determinations from the documentation and opinion submitted 437  
pursuant to divisions (A) (3) (a) and (b) of this section: 438

(i) Incurred claims for diagnostic and treatment services 439  
for biologically based mental illnesses for a period of at least 440  
six months independently caused the health insuring 441  
corporation's costs for claims and administrative expenses for 442  
the coverage of basic health care services to increase by more 443  
than one per cent per year. 444

(ii) The increase in costs reasonably justifies an 445  
increase of more than one per cent in the annual premiums or 446  
rates charged by the health insuring corporation for the 447  
coverage of basic health care services. 448

Any determination made by the superintendent under this 449

division is subject to Chapter 119. of the Revised Code.	450
(B) (1) "Supplemental health care services" means any	451
health care services other than basic health care services that	452
a health insuring corporation may offer, alone or in combination	453
with either basic health care services or other supplemental	454
health care services, and includes:	455
(a) Services of facilities for intermediate or long-term	456
care, or both;	457
(b) Dental care services;	458
(c) Vision care and optometric services including lenses	459
and frames;	460
(d) Podiatric care or foot care services;	461
(e) Mental health services, excluding diagnostic and	462
treatment services for biologically based mental illnesses;	463
(f) Short-term outpatient evaluative and crisis-	464
intervention mental health services;	465
(g) Medical or psychological treatment and referral	466
services for alcohol and drug abuse or addiction;	467
(h) Home health services;	468
(i) Prescription drug services;	469
(j) Nursing services;	470
(k) Services of a dietitian licensed under Chapter 4759.	471
of the Revised Code;	472
(l) Physical therapy services;	473
(m) Chiropractic services;	474

(n) Any other category of services approved by the superintendent of insurance.	475 476
(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.	477 478 479 480 481
(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.	482 483 484 485 486
(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.	487 488 489 490 491 492 493
(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.	494 495
(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.	496 497 498
(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.	499 500 501
(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of	502 503

another state. 504

(I) "Emergency health services" means those health care 505  
services that must be available on a seven-days-per-week, 506  
twenty-four-hours-per-day basis in order to prevent jeopardy to 507  
an enrollee's health status that would occur if such services 508  
were not received as soon as possible, and includes, where 509  
appropriate, provisions for transportation and indemnity 510  
payments or service agreements for out-of-area coverage. 511

(J) "Enrollee" means any natural person who is entitled to 512  
receive health care benefits provided by a health insuring 513  
corporation. 514

(K) "Evidence of coverage" means any certificate, 515  
agreement, policy, or contract issued to a subscriber that sets 516  
out the coverage and other rights to which such person is 517  
entitled under a health care plan. 518

(L) "Health care facility" means any facility, except a 519  
health care practitioner's office, that provides preventive, 520  
diagnostic, therapeutic, acute convalescent, rehabilitation, 521  
mental health, intellectual disability, intermediate care, or 522  
skilled nursing services. 523

(M) "Health care services" means basic, supplemental, and 524  
specialty health care services. 525

(N) "Health delivery network" means any group of providers 526  
or health care facilities, or both, or any representative 527  
thereof, that have entered into an agreement to offer health 528  
care services in a panel rather than on an individual basis. 529

(O) "Health insuring corporation" means a corporation, as 530  
defined in division (H) of this section, that, pursuant to a 531  
policy, contract, certificate, or agreement, pays for, 532

reimburses, or provides, delivers, arranges for, or otherwise 533  
makes available, basic health care services, supplemental health 534  
care services, or specialty health care services, or a 535  
combination of basic health care services and either 536  
supplemental health care services or specialty health care 537  
services, through either an open panel plan or a closed panel 538  
plan. 539

"Health insuring corporation" does not include a limited 540  
liability company formed pursuant to Chapter 1705. of the 541  
Revised Code, an insurer licensed under Title XXXIX of the 542  
Revised Code if that insurer offers only open panel plans under 543  
which all providers and health care facilities participating 544  
receive their compensation directly from the insurer, a 545  
corporation formed by or on behalf of a political subdivision or 546  
a department, office, or institution of the state, or a public 547  
entity formed by or on behalf of a board of county 548  
commissioners, a county board of developmental disabilities, an 549  
alcohol and drug addiction services board, a board of alcohol, 550  
drug addiction, and mental health services, or a community 551  
mental health board, as those terms are used in Chapters 340. 552  
and 5126. of the Revised Code. Except as provided by division 553  
(D) of section 1751.02 of the Revised Code, or as otherwise 554  
provided by law, no board, commission, agency, or other entity 555  
under the control of a political subdivision may accept 556  
insurance risk in providing for health care services. However, 557  
nothing in this division shall be construed as prohibiting such 558  
entities from purchasing the services of a health insuring 559  
corporation or a third-party administrator licensed under 560  
Chapter 3959. of the Revised Code. 561

(P) "Intermediary organization" means a health delivery 562  
network or other entity that contracts with licensed health 563

insuring corporations or self-insured employers, or both, to 564  
provide health care services, and that enters into contractual 565  
arrangements with other entities for the provision of health 566  
care services for the purpose of fulfilling the terms of its 567  
contracts with the health insuring corporations and self-insured 568  
employers. 569

(Q) "Intermediate care" means residential care above the 570  
level of room and board for patients who require personal 571  
assistance and health-related services, but who do not require 572  
skilled nursing care. 573

(R) "Medical record" means the personal information that 574  
relates to an individual's physical or mental condition, medical 575  
history, or medical treatment. 576

(S) (1) "Open panel plan" means a health care plan that 577  
provides incentives for enrollees to use participating providers 578  
and that also allows enrollees to use providers that are not 579  
participating providers. 580

(2) No health insuring corporation may offer an open panel 581  
plan, unless the health insuring corporation is also licensed as 582  
an insurer under Title XXXIX of the Revised Code, the health 583  
insuring corporation, on June 4, 1997, holds a certificate of 584  
authority or license to operate under Chapter 1736. or 1740. of 585  
the Revised Code, or an insurer licensed under Title XXXIX of 586  
the Revised Code is responsible for the out-of-network risk as 587  
evidenced by both an evidence of coverage filing under section 588  
1751.11 of the Revised Code and a policy and certificate filing 589  
under section 3923.02 of the Revised Code. 590

(T) "Osteopathic hospital" means a hospital registered 591  
under section 3701.07 of the Revised Code that advocates 592

osteopathic principles and the practice and perpetuation of 593  
osteopathic medicine by doing any of the following: 594

(1) Maintaining a department or service of osteopathic 595  
medicine or a committee on the utilization of osteopathic 596  
principles and methods, under the supervision of an osteopathic 597  
physician; 598

(2) Maintaining an active medical staff, the majority of 599  
which is comprised of osteopathic physicians; 600

(3) Maintaining a medical staff executive committee that 601  
has osteopathic physicians as a majority of its members. 602

(U) "Panel" means a group of providers or health care 603  
facilities that have joined together to deliver health care 604  
services through a contractual arrangement with a health 605  
insuring corporation, employer group, or other payor. 606

(V) "Person" has the same meaning as in section 1.59 of 607  
the Revised Code, and, unless the context otherwise requires, 608  
includes any insurance company holding a certificate of 609  
authority under Title XXXIX of the Revised Code, any subsidiary 610  
and affiliate of an insurance company, and any government 611  
agency. 612

(W) "Premium rate" means any set fee regularly paid by a 613  
subscriber to a health insuring corporation. A "premium rate" 614  
does not include a one-time membership fee, an annual 615  
administrative fee, or a nominal access fee, paid to a managed 616  
health care system under which the recipient of health care 617  
services remains solely responsible for any charges assessed for 618  
those services by the provider or health care facility. 619

(X) "Primary care provider" means a provider that is 620  
designated by a health insuring corporation to supervise, 621

coordinate, or provide initial care or continuing care to an 622  
enrollee, and that may be required by the health insuring 623  
corporation to initiate a referral for specialty care and to 624  
maintain supervision of the health care services rendered to the 625  
enrollee. 626

(Y) "Provider" means any natural person or partnership of 627  
natural persons who are licensed, certified, accredited, or 628  
otherwise authorized in this state to furnish health care 629  
services, or any professional association organized under 630  
Chapter 1785. of the Revised Code, provided that nothing in this 631  
chapter or other provisions of law shall be construed to 632  
preclude a health insuring corporation, health care 633  
practitioner, or organized health care group associated with a 634  
health insuring corporation from employing certified nurse 635  
practitioners, certified nurse anesthetists, clinical nurse 636  
specialists, certified nurse-midwives, pharmacists, dietitians, 637  
physician assistants, dental assistants, dental hygienists, 638  
optometric technicians, or other allied health personnel who are 639  
licensed, certified, accredited, or otherwise authorized in this 640  
state to furnish health care services. 641

(Z) "Provider sponsored organization" means a corporation, 642  
as defined in division (H) of this section, that is at least 643  
eighty per cent owned or controlled by one or more hospitals, as 644  
defined in section 3727.01 of the Revised Code, or one or more 645  
physicians licensed to practice medicine or surgery or 646  
osteopathic medicine and surgery under Chapter 4731. of the 647  
Revised Code, or any combination of such physicians and 648  
hospitals. Such control is presumed to exist if at least eighty 649  
per cent of the voting rights or governance rights of a provider 650  
sponsored organization are directly or indirectly owned, 651  
controlled, or otherwise held by any combination of the 652

physicians and hospitals described in this division. 653

(AA) "Solicitation document" means the written materials 654  
provided to prospective subscribers or enrollees, or both, and 655  
used for advertising and marketing to induce enrollment in the 656  
health care plans of a health insuring corporation. 657

(BB) "Subscriber" means a person who is responsible for 658  
making payments to a health insuring corporation for 659  
participation in a health care plan, or an enrollee whose 660  
employment or other status is the basis of eligibility for 661  
enrollment in a health insuring corporation. 662

(CC) "Urgent care services" means those health care 663  
services that are appropriately provided for an unforeseen 664  
condition of a kind that usually requires medical attention 665  
without delay but that does not pose a threat to the life, limb, 666  
or permanent health of the injured or ill person, and may 667  
include such health care services provided out of the health 668  
insuring corporation's approved service area pursuant to 669  
indemnity payments or service agreements. 670

**Sec. 1751.05.** (A) The superintendent of insurance shall 671  
issue or deny a certificate of authority to a health insuring 672  
corporation filing an application pursuant to section 1751.03 of 673  
the Revised Code, one hundred thirty-five days from the 674  
superintendent's receipt of a complete application and 675  
accompanying documents. 676

(B) A certificate of authority shall be issued upon 677  
payment of the application fee prescribed in section 1751.44 of 678  
the Revised Code if the superintendent is satisfied that the 679  
following conditions are met: 680

(1) The persons responsible for the conduct of the affairs 681

of the applicant are competent, trustworthy, and possess good 682  
reputations. 683

(2) The superintendent determines, in accordance with 684  
division (B) of section 1751.04 of the Revised Code, that the 685  
organization's proposed plan of operation meets the requirements 686  
of division (A) of that section. 687

(3) The applicant constitutes an appropriate mechanism to 688  
effectively provide or arrange for the provision of the basic 689  
health care services, supplemental health care services, or 690  
specialty health care services to be provided to enrollees. 691

(4) The applicant is financially responsible, complies 692  
with section 1751.28 of the Revised Code, and may reasonably be 693  
expected to meet its obligations to enrollees and prospective 694  
enrollees. In making this determination, the superintendent may 695  
consider: 696

(a) The financial soundness of the applicant's 697  
arrangements for health care services, including the applicant's 698  
proposed contractual periodic prepayments or premiums and the 699  
use of copayments and deductibles; 700

(b) The adequacy of working capital; 701

(c) Any agreement with an insurer, a government, or any 702  
other person for insuring the payment of the cost of health care 703  
services or providing for automatic applicability of an 704  
alternative coverage in the event of discontinuance of the 705  
health insuring corporation's operations; 706

(d) Any agreement with providers or health care facilities 707  
for the provision of health care services; 708

(e) Any deposit of securities submitted in accordance with 709

section 1751.27 of the Revised Code as a guarantee that the obligations will be performed. (5) The applicant has submitted documentation of an arrangement to provide health care services to its enrollees until the expiration of the enrollees' contracts with the applicant if a health care plan or the operations of the health insuring corporation are discontinued prior to the expiration of the enrollees' contracts. An arrangement to provide health care services may be made by using any one, or any combination, of the following methods:

- (a) The maintenance of insolvency insurance;
- (b) A provision in contracts with providers and health care facilities, but no health insuring corporation shall rely solely on such a provision for more than thirty days;
- (c) An agreement with other health insuring corporations or insurers, providing enrollees with automatic conversion rights upon the discontinuation of a health care plan or the health insuring corporation's operations;
- (d) Such other methods as approved by the superintendent.

(6) Nothing in the applicant's proposed method of operation, as shown by the information submitted pursuant to section 1751.03 of the Revised Code or by independent investigation, will cause harm to an enrollee or to the public at large, as determined by the superintendent.

(7) Any deficiencies identified by the superintendent under section 1751.04 of the Revised Code have been corrected.

(8) The applicant has deposited securities as set forth in section 1751.27 of the Revised Code.

(C) If an applicant elects to fulfill the requirements of 738  
division (B) (5) of this section through an agreement with other 739  
health insuring corporations or insurers, the agreement shall 740  
require those health insuring corporations or insurers to give 741  
thirty days' notice to the superintendent prior to cancellation 742  
or discontinuation of the agreement for any reason. 743

(D) A certificate of authority shall be denied only after 744  
compliance with the requirements of section 1751.36 of the 745  
Revised Code. 746

**Sec. 1751.06.** Upon obtaining a certificate of authority as 747  
required under this chapter, a health insuring corporation may 748  
do all of the following: 749

(A) Enroll individuals and their dependents in either of 750  
the following circumstances: 751

(1) The individual resides or lives in the approved 752  
service area. 753

(2) The individual's place of employment is located in the 754  
approved service area. 755

(B) Contract with providers and health care facilities for 756  
the health care services to which enrollees are entitled under 757  
the terms of the health insuring corporation's health care 758  
contracts; 759

(C) Contract with insurance companies authorized to do 760  
business in this state for insurance, indemnity, or 761  
reimbursement against the cost of providing emergency and 762  
nonemergency health care services for enrollees, subject to the 763  
provisions set forth in this chapter and the limitations set 764  
forth in the Revised Code; 765

(D) Contract with any person pursuant to the requirements 766  
of division (A) (18) of section 1751.03 of the Revised Code for 767  
managerial or administrative services, or for data processing, 768  
actuarial analysis, billing services, or any other services 769  
authorized by the superintendent of insurance. However, a health 770  
insuring corporation shall not enter into a contract for any of 771  
the services listed in this division with an insurance company 772  
that is not authorized to engage in the business of insurance in 773  
this state. 774

(E) Accept from governmental agencies, private agencies, 775  
corporations, associations, groups, individuals, or other 776  
persons, payments covering all or part of the costs of planning, 777  
development, construction, and the provision of health care 778  
services; 779

(F) Purchase, lease, construct, renovate, operate, or 780  
maintain health care facilities, and their ancillary equipment, 781  
and any property necessary in the transaction of the business of 782  
the health insuring corporation; 783

(G) In the employer group market, impose an affiliation 784  
period of not more than sixty days, or for late enrollees an 785  
affiliation period of not more than ninety days, which period 786  
begins on the individual's date of enrollment and runs 787  
concurrently with any waiting period imposed under the coverage. 788  
For purposes of this division, "affiliation period" means a 789  
period of time which, under the terms of the coverage offered, 790  
must expire before the coverage becomes effective. No health 791  
care services or benefits need to be provided during an 792  
affiliation period, and no periodic prepayments can be charged 793  
for any coverage during that period. 794

(H) If a health insuring corporation offers coverage in 795

the small employer group market through a network plan, limit or 796  
deny the coverage in accordance with section 3924.031 of the 797  
Revised Code; 798

(I) Refuse to issue coverage in the small employer group 799  
market pursuant to section 3924.032 of the Revised Code; 800

(J) Establish employer contribution rules or group 801  
participation rules for the offering of coverage in connection 802  
with a group contract in the small employer group market, as 803  
provided in division ~~(E)~~(D) (1) of section 3924.03 of the Revised 804  
Code. 805

Nothing in this section shall be construed as prohibiting 806  
a health insuring corporation without other commercial 807  
enrollment from contracting solely with federal health care 808  
programs regulated by federal regulatory bodies. 809

Nothing in this section shall be construed to limit the 810  
authority of a health insuring corporation to perform those 811  
functions not otherwise prohibited by law. 812

**Sec. 1751.12.** (A) (1) No contractual periodic prepayment 813  
and no premium rate for nongroup and conversion policies for 814  
health care services, or any amendment to them, may be used by 815  
any health insuring corporation at any time until the 816  
contractual periodic prepayment and premium rate, or amendment, 817  
have been filed with the superintendent of insurance, and shall 818  
not be effective until the expiration of sixty days after their 819  
filing unless the superintendent sooner gives approval. The 820  
filing shall be accompanied by an actuarial certification in the 821  
form prescribed by the superintendent. The superintendent shall 822  
disapprove the filing, if the superintendent determines within 823  
the sixty-day period that the contractual periodic prepayment or 824

premium rate, or amendment, is not in accordance with sound 825  
actuarial principles or is not reasonably related to the 826  
applicable coverage and characteristics of the applicable class 827  
of enrollees. The superintendent shall notify the health 828  
insuring corporation of the disapproval, and it shall thereafter 829  
be unlawful for the health insuring corporation to use the 830  
contractual periodic prepayment or premium rate, or amendment. 831

(2) No contractual periodic prepayment for group policies 832  
for health care services shall be used until the contractual 833  
periodic prepayment has been filed with the superintendent. The 834  
filing shall be accompanied by an actuarial certification in the 835  
form prescribed by the superintendent. The superintendent may 836  
reject a filing made under division (A)(2) of this section at 837  
any time, with at least thirty days' written notice to a health 838  
insuring corporation, if the contractual periodic prepayment is 839  
not in accordance with sound actuarial principles or is not 840  
reasonably related to the applicable coverage and 841  
characteristics of the applicable class of enrollees. 842

(3) At any time, the superintendent, upon at least thirty 843  
days' written notice to a health insuring corporation, may 844  
withdraw the approval given under division (A)(1) of this 845  
section, deemed or actual, of any contractual periodic 846  
prepayment or premium rate, or amendment, based on information 847  
that either of the following applies: 848

(a) The contractual periodic prepayment or premium rate, 849  
or amendment, is not in accordance with sound actuarial 850  
principles. 851

(b) The contractual periodic prepayment or premium rate, 852  
or amendment, is not reasonably related to the applicable 853  
coverage and characteristics of the applicable class of 854

enrollees. 855

(4) Any disapproval under division (A) (1) of this section, 856  
any rejection of a filing made under division (A) (2) of this 857  
section, or any withdrawal of approval under division (A) (3) of 858  
this section, shall be effected by a written notice, which shall 859  
state the specific basis for the disapproval, rejection, or 860  
withdrawal and shall be issued in accordance with Chapter 119. 861  
of the Revised Code. 862

(B) Notwithstanding division (A) of this section, a health 863  
insuring corporation may use a contractual periodic prepayment 864  
or premium rate for policies used for the coverage of 865  
beneficiaries enrolled in medicare pursuant to a medicare risk 866  
contract or medicare cost contract, or for policies used for the 867  
coverage of beneficiaries enrolled in the federal employees 868  
health benefits program pursuant to 5 U.S.C.A. 8905, or for 869  
policies used for the coverage of medicaid recipients, or for 870  
policies used for the coverage of beneficiaries under any other 871  
federal health care program regulated by a federal regulatory 872  
body, or for policies used for the coverage of beneficiaries 873  
under any contract covering officers or employees of the state 874  
that has been entered into by the department of administrative 875  
services, if both of the following apply: 876

(1) The contractual periodic prepayment or premium rate 877  
has been approved by the United States department of health and 878  
human services, the United States office of personnel 879  
management, the department of medicaid, or the department of 880  
administrative services. 881

(2) The contractual periodic prepayment or premium rate is 882  
filed with the superintendent prior to use and is accompanied by 883  
documentation of approval from the United States department of 884

health and human services, the United States office of personnel 885  
management, the department of medicaid, or the department of 886  
administrative services. 887

(C) The administrative expense portion of all contractual 888  
periodic prepayment or premium rate filings submitted to the 889  
superintendent for review must reflect the actual cost of 890  
administering the product. The superintendent may require that 891  
the administrative expense portion of the filings be itemized 892  
and supported. 893

(D) (1) Copayments, cost sharing, and deductibles must be 894  
reasonable and must not be a barrier to the necessary 895  
utilization of services by enrollees. 896

(2) A health insuring corporation, in order to ensure that 897  
copayments, cost sharing, and deductibles are reasonable and not 898  
a barrier to the necessary utilization of basic health care 899  
services by enrollees shall impose copayment charges, cost 900  
sharing, and deductible charges that annually do not exceed 901  
forty per cent of the total annual cost to the health insuring 902  
corporation of providing all covered health care services when 903  
applied to a standard population expected to be covered under 904  
the filed product in question. The total annual cost of 905  
providing a health care service is the cost to the health 906  
insuring corporation of providing the health care service to its 907  
enrollees as reduced by any applicable provider discount. This 908  
requirement shall be demonstrated by an actuary who is a member 909  
of the American academy of actuaries and qualified to provide 910  
such certifications as described in the United States 911  
qualification standards promulgated by the American academy of 912  
actuaries pursuant to the code of professional conduct. 913

(3) For purposes of division (D) of this section, all of 914

the following apply: 915

(a) Copayments imposed by health insuring corporations in 916  
connection with a high deductible health plan that is linked to 917  
a health savings account are reasonable and are not a barrier to 918  
the necessary utilization of services by enrollees. 919

(b) Division (D) (2) of this section does not apply to a 920  
high deductible health plan that is linked to a health savings 921  
account. 922

(c) Catastrophic-only plans, as described in division (D) 923  
(2) of section 3902.53 of the Revised Code and defined under the 924  
"Patient Protection and Affordable Care Act," 124 Stat. 119, 42 925  
U.S.C. 18022 and any related regulations, are not subject to the 926  
limits prescribed in division (D) of this section, provided that 927  
such plans meet all applicable minimum federal requirements. 928

(E) A health insuring corporation shall not impose 929  
lifetime maximums on basic health care services. However, a 930  
health insuring corporation may establish a benefit limit for 931  
inpatient hospital services that are provided pursuant to a 932  
policy, contract, certificate, or agreement for supplemental 933  
health care services. 934

(F) The superintendent may adopt rules allowing different 935  
copayment, cost sharing, and deductible amounts for plans with a 936  
medical savings account, health reimbursement arrangement, 937  
flexible spending account, or similar account; 938

(G) A health insuring corporation may impose higher 939  
copayment, cost sharing, and deductible charges under health 940  
plans if requested by the group contract, policy, certificate, 941  
or agreement holder, or an individual seeking coverage under an 942  
individual health plan. This shall not be construed as requiring 943

the health insuring corporation to create customized health 944  
plans for group contract holders or individuals. 945

(H) As used in this section, "health savings account" and 946  
"high deductible health plan" have the same meanings as in the 947  
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, 948  
as amended. 949

**Sec. 1751.16.** (A) Except as provided in division (F) of 950  
this section, every group contract issued by a health insuring 951  
corporation shall provide an option for conversion to an 952  
individual contract issued on a direct-payment basis to any 953  
subscriber covered by the group contract who terminates 954  
employment or membership in the group, unless: 955

(1) Termination of the conversion option or contract is 956  
based upon nonpayment of premium after reasonable notice in 957  
writing has been given by the health insuring corporation to the 958  
subscriber. 959

(2) The subscriber is, or is eligible to be, covered for 960  
benefits at least comparable to the group contract under any of 961  
the following: 962

(a) Medicare; 963

(b) Any act of congress or law under this or any other 964  
state of the United States providing coverage at least 965  
comparable to the benefits under division (A) (2) (a) of this 966  
section; 967

(c) Any policy of insurance or health care plan providing 968  
coverage at least comparable to the benefits under division (A) 969  
(2) (a) of this section. 970

~~(B) (1) The direct-payment contract offered by the health-~~ 971

~~insuring corporation pursuant to division (A) of this section~~ 972  
~~shall provide the following:~~ 973

~~(a) In the case of an individual who is not a federally~~ 974  
~~eligible individual, benefits comparable to benefits in any of~~ 975  
~~the individual contracts then being issued to individual~~ 976  
~~subscribers by the health insuring corporation;~~ 977

~~(b) In the case of a federally eligible individual, a~~ 978  
~~basic and standard plan established under section 3924.10 of the~~ 979  
~~Revised Code or plans substantially similar to the basic and~~ 980  
~~standard plan in benefit design and scope of covered services.~~ 981  
~~For purposes of division (B) (1) (b) of this section, the~~ 982  
~~superintendent of insurance shall determine whether a plan is~~ 983  
~~substantially similar to the basic or standard plan in benefit~~ 984  
~~design and scope of covered services. The contractual periodic~~ 985  
~~prepayments charged for such plans may not exceed the amounts~~ 986  
~~specified below:~~ 987

~~(i) For calendar years 2010 and 2011, an amount that is~~ 988  
~~two times the base rate charged any other individual of a group~~ 989  
~~to which the organization is currently accepting new business~~ 990  
~~and for which similar copayments and deductibles are applied;~~ 991

~~(ii) For calendar year 2012 and every calendar year~~ 992  
~~thereafter, an amount that is one and one half times the base~~ 993  
~~rate charged any other individual of a group to which the health-~~ 994  
~~insuring corporation is currently accepting new business and for~~ 995  
~~which similar copayments and deductibles are applied, unless the~~ 996  
~~superintendent of insurance determines that the amendments by~~ 997  
~~this act to sections 3923.58 and 3923.581 of the Revised Code,~~ 998  
~~have resulted in the market wide average medical loss ratio for~~ 999  
~~coverage sold to individual insureds and nonemployer group~~ 1000  
~~insureds in this state, including open enrollment insureds, to~~ 1001

~~increase by more than five and one quarter percentage points— 1002  
during calendar year 2010. If the superintendent makes that— 1003  
determination, the premium limit established by division (B) (1)— 1004  
(b) (i) of this section shall remain in effect. 1005~~

~~(2) The direct payment contract offered pursuant to 1006  
division (A) of this section may include a coordination of 1007  
benefits provision as approved by the superintendent. 1008~~

~~(3) For purposes of division (B) of this section: 1009~~

~~(a) "Federally eligible individual" means an eligible— 1010  
individual as defined in 45 C.F.R. 148.103. 1011~~

~~(b) "Base rate" means, as to any health benefit plan that— 1012  
is issued by a health insuring corporation, the lowest premium— 1013  
rate for new or existing business prescribed by the health— 1014  
insuring corporation for the same or similar coverage under a— 1015  
plan or arrangement covering any individual in a group with— 1016  
similar case characteristics. 1017~~

~~(C) The option for conversion shall be available: 1018~~

~~(1) Upon the death of the subscriber, to the surviving 1019  
spouse with respect to such of the spouse and dependents as are 1020  
then covered by the group contract; 1021~~

~~(2) To a child solely with respect to the child upon the 1022  
child's attaining the limiting age of coverage under the group 1023  
contract while covered as a dependent under the contract; 1024~~

~~(3) Upon the divorce, dissolution, or annulment of the 1025  
marriage of the subscriber, to the divorced spouse, or, in the 1026  
event of annulment, to the former spouse of the subscriber. 1027~~

~~(D) No health insuring corporation shall use age or health 1028  
status as the basis for refusing to renew a converted contract. 1029~~

(E) Written notice of the conversion option provided by 1030  
this section shall be given to the subscriber by the health 1031  
insuring corporation by mail. The notice shall be sent to the 1032  
subscriber's address in the records of the employer upon receipt 1033  
of notice from the employer of the event giving rise to the 1034  
conversion option. If the subscriber has not received notice of 1035  
the conversion privilege at least fifteen days prior to the 1036  
expiration of the thirty-day conversion period, then the 1037  
subscriber shall have an additional period within which to 1038  
exercise the privilege. This additional period shall expire 1039  
fifteen days after the subscriber receives notice, but in no 1040  
event shall the period extend beyond sixty days after the 1041  
expiration of the thirty-day conversion period. 1042

(F) This section does not apply to any group contract 1043  
offering only supplemental health care services or specialty 1044  
health care services. 1045

**Sec. 1751.18.** (A) (1) No health insuring corporation shall 1046  
cancel or fail to renew the coverage of a subscriber or enrollee 1047  
because of any health status-related factor in relation to the 1048  
subscriber or enrollee, the subscriber's or enrollee's 1049  
requirements for health care services, or for any other reason 1050  
designated under rules adopted by the superintendent of 1051  
insurance. 1052

(2) Unless otherwise required by state or federal law, no 1053  
health insuring corporation, or health care facility or provider 1054  
through which the health insuring corporation has made 1055  
arrangements to provide health care services, shall discriminate 1056  
against any individual with regard to enrollment, disenrollment, 1057  
or the quality of health care services rendered, on the basis of 1058  
the individual's race, color, sex, age, religion, military 1059

status as defined in section 4112.01 of the Revised Code, or 1060  
status as a recipient of medicare or medicaid, or any health 1061  
status-related factor in relation to the individual. However, a 1062  
health insuring corporation shall not be required to accept a 1063  
recipient of medicare or medical assistance, if an agreement has 1064  
not been reached on appropriate payment mechanisms between the 1065  
health insuring corporation and the governmental agency 1066  
administering these programs. ~~Further, except for open-~~ 1067  
~~enrollment coverage under sections 3923.58 and 3923.581 of the-~~ 1068  
~~Revised Code and except as provided in section 1751.65 of the-~~ 1069  
~~Revised Code, a health insuring corporation may reject an-~~ 1070  
~~applicant for nongroup enrollment on the basis of any health-~~ 1071  
~~status related factor in relation to the applicant.~~ 1072

(B) A health insuring corporation may cancel or decide not 1073  
to renew the coverage of an enrollee if the enrollee has 1074  
performed an act or practice that constitutes fraud or 1075  
intentional misrepresentation of material fact under the terms 1076  
of the coverage and if the cancellation or nonrenewal is not 1077  
based, either directly or indirectly, on any health status- 1078  
related factor in relation to the enrollee. 1079

(C) An enrollee may appeal any action or decision of a 1080  
health insuring corporation taken pursuant to section 2742(b) to 1081  
(e) of the "Health Insurance Portability and Accountability Act 1082  
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1083  
300gg-42, as amended. To appeal, the enrollee may submit a 1084  
written complaint to the health insuring corporation pursuant to 1085  
section 1751.19 of the Revised Code. The enrollee may, within 1086  
thirty days after receiving a written response from the health 1087  
insuring corporation, appeal the health insuring corporation's 1088  
action or decision to the superintendent. 1089

(D) As used in this section, "health status-related factor" means any of the following:	1090 1091
(1) Health status;	1092
(2) Medical condition, including both physical and mental illnesses;	1093 1094
(3) Claims experience;	1095
(4) Receipt of health care;	1096
(5) Medical history;	1097
(6) Genetic information;	1098
(7) Evidence of insurability, including conditions arising out of acts of domestic violence;	1099 1100
(8) Disability.	1101
<b>Sec. 1751.58.</b> Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following conditions apply to all group health insuring corporation contracts that are sold in connection with an employment-related group health care plan and that are not subject to section 3924.03 of the Revised Code:	1102 1103 1104 1105 1106 1107 1108
(A) (1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a health insuring corporation offers coverage in the small or large group market in connection with a group contract, the corporation shall renew or continue in force such coverage at the option of the contract holder.	1109 1110 1111 1112 1113 1114
(2) A health insuring corporation may cancel or decide not to renew the coverage of any eligible employee or of a dependent	1115 1116

of an eligible employee under the group contract in accordance 1117  
with division (B) of section 1751.18 of the Revised Code. 1118

(B) Such group contracts are subject to ~~division (A)(3) of~~ 1119  
~~section 3924.03 and~~ sections 3924.033 and 3924.27 of the Revised 1120  
Code. 1121

(C) Such group contracts shall provide for the special 1122  
enrollment periods described in section 2701(f) of the "Health 1123  
Insurance Portability and Accountability Act of 1996." 1124

(D) At least once in every twelve-month period, a health 1125  
insuring corporation shall provide to all late enrollees, as 1126  
defined in section 3924.01 of the Revised Code, who are 1127  
identified by the contract holder, the option to enroll in the 1128  
group contract. The enrollment option shall be provided for a 1129  
minimum period of thirty consecutive days. All delays of 1130  
coverage imposed under the group contract, including any 1131  
affiliation period, shall begin on the date the health insuring 1132  
corporation receives notice of the late enrollee's application 1133  
or request for coverage, and shall run concurrently with each 1134  
other. 1135

**Sec. 1751.69.** (A) As used in this section, "cost sharing" 1136  
means the cost to an individual insured under an individual or 1137  
group health insuring corporation policy, contract, or agreement 1138  
according to any coverage limit, copayment, coinsurance, 1139  
deductible, or other out-of-pocket expense requirements imposed 1140  
by the policy, contract, or agreement. 1141

(B) Notwithstanding section 3901.71 of the Revised Code 1142  
and subject to division (D) of this section, no individual or 1143  
group health insuring corporation policy, contract, or agreement 1144  
providing basic health care services or prescription drug 1145

services that is delivered, issued for delivery, or renewed in 1146  
this state, if the policy, contract, or agreement provides 1147  
coverage for cancer chemotherapy treatment, shall fail to comply 1148  
with either of the following: 1149

(1) The policy, contract, or agreement shall not provide 1150  
coverage or impose cost sharing for a prescribed, orally 1151  
administered cancer medication on a less favorable basis than 1152  
the coverage it provides or cost sharing it imposes for 1153  
intravenously administered or injected cancer medications. 1154

(2) The policy, contract, or agreement shall not comply 1155  
with division (B)(1) of this section by imposing an increase in 1156  
cost sharing solely for orally administered, intravenously 1157  
administered, or injected cancer medications. 1158

(C) Notwithstanding any provision of this section to the 1159  
contrary, an individual or group health insuring corporation 1160  
policy, contract, or agreement shall be deemed to be in 1161  
compliance with this section if the cost sharing imposed under 1162  
such a policy, contract, or agreement for orally administered 1163  
cancer treatments does not exceed one hundred dollars per 1164  
prescription fill. The cost-sharing limit of one hundred dollars 1165  
per prescription fill shall apply to a high deductible plan, as 1166  
defined in 26 U.S.C. 223, or a catastrophic plan, as described 1167  
in division (D)(2) of section 3902.53 of the Revised Code and 1168  
defined in 42 U.S.C. 18022, only after the deductible has been 1169  
met. 1170

(D) The prohibitions in division (B) of this section do 1171  
not preclude an individual or group health insuring corporation 1172  
policy, contract, or agreement from requiring an enrollee to 1173  
obtain prior authorization before orally administered cancer 1174  
medication is dispensed to the enrollee. 1175

(E) A health insuring corporation that offers coverage for 1176  
basic health care services is not required to comply with 1177  
division (B) of this section if all of the following apply: 1178

(1) The health insuring corporation submits documentation 1179  
certified by an independent member of the American academy of 1180  
actuaries to the superintendent of insurance showing that 1181  
compliance with division (B) (1) of this section for a period of 1182  
at least six months independently caused the health insuring 1183  
corporation's costs for claims and administrative expenses for 1184  
the coverage of basic health care services to increase by more 1185  
than one per cent per year. 1186

(2) The health insuring corporation submits a signed 1187  
letter from an independent member of the American academy of 1188  
actuaries to the superintendent of insurance opining that the 1189  
increase in costs described in division (E) (1) of this section 1190  
could reasonably justify an increase of more than one per cent 1191  
in the annual premiums or rates charged by the health insuring 1192  
corporation for the coverage of basic health care services. 1193

(3) (a) The superintendent of insurance makes the following 1194  
determinations from the documentation and opinion submitted 1195  
pursuant to divisions (E) (1) and (2) of this section: 1196

(i) Compliance with division (B) (1) of this section for a 1197  
period of at least six months independently caused the health 1198  
insuring corporation's costs for claims and administrative 1199  
expenses for the coverage of basic health care services to 1200  
increase more than one per cent per year. 1201

(ii) The increase in costs reasonably justifies an 1202  
increase of more than one per cent in the annual premiums or 1203  
rates charged by the health insuring corporation for the 1204

coverage of basic health care services. 1205

(b) Any determination made by the superintendent under 1206  
division (E) (3) of this section is subject to Chapter 119. of 1207  
the Revised Code. 1208

Sec. 3902.50. As used in sections 3902.50 to 3902.54 of 1209  
the Revised Code: 1210

(A) "Cost-sharing" means the cost to a covered person 1211  
under a health benefit plan according to any coverage limit, 1212  
copayment, coinsurance, deductible, or other out-of-pocket 1213  
expense requirement. 1214

(B) "Covered person," "health benefit plan," "health care 1215  
provider" or "provider," "health care services," and "health 1216  
plan issuer" have the same meanings as in section 3922.01 of the 1217  
Revised Code. 1218

(C) "Preexisting condition exclusion" means, with respect 1219  
to a health benefit plan, a limitation or exclusion of benefits 1220  
relating to a condition based on the fact that the condition was 1221  
present before the date of enrollment in the plan, whether or 1222  
not any medical advice, diagnosis, care, or treatment was 1223  
recommended or received before such date. "Condition" does not 1224  
include genetic information in the absence of a diagnosis of the 1225  
condition related to such information. 1226

Sec. 3902.51. (A) With respect to the premium rate charged 1227  
by a health plan issuer for a health benefit plan offered in the 1228  
individual or small group market, all of the following apply: 1229

(1) The premium rate shall vary with respect to the health 1230  
benefit plan involved only by the following: 1231

(a) Whether the health benefit plan covers an individual 1232

<u>or family;</u>	1233
<u>(b) Rating area, as established in accordance with</u>	1234
<u>division (C) (1) of this section;</u>	1235
<u>(c) Age, except that such rate shall not vary by more than</u>	1236
<u>three to one for adults;</u>	1237
<u>(d) Tobacco use, except that such rate shall not vary by</u>	1238
<u>more than one and one-half to one.</u>	1239
<u>(2) The premium rate shall not vary with respect to the</u>	1240
<u>health benefit plan involved by any other factor not described</u>	1241
<u>in division (A) of this section.</u>	1242
<u>(B) With respect to family coverage under a health benefit</u>	1243
<u>plan, the rating variations permitted under divisions (A) (1) (c)</u>	1244
<u>and (d) of this section shall be applied based on the portion of</u>	1245
<u>the premium that is attributable to each family member covered</u>	1246
<u>under the health benefit plan.</u>	1247
<u>(C) The superintendent of insurance shall adopt rules to</u>	1248
<u>do the following:</u>	1249
<u>(1) Establish one or more rating areas within the state;</u>	1250
<u>(2) Define the permissible age bands for rating purposes</u>	1251
<u>under division (A) (3) of this section.</u>	1252
<u>(D) A health plan issuer shall not establish lifetime or</u>	1253
<u>annual limits on the dollar value of benefits described in</u>	1254
<u>section 3902.53 of the Revised Code for any covered person.</u>	1255
<b><u>Sec. 3902.52. (A) Every individual health benefit plan</u></b>	1256
<b><u>shall accept every individual in this state who applies for</u></b>	1257
<b><u>coverage and every group health benefit plan shall accept every</u></b>	1258
<b><u>employer in this state that applies for coverage, regardless of</u></b>	1259

whether any individual or employee has a preexisting condition. 1260  
A health benefit plan may restrict enrollment in coverage to 1261  
open or special enrollment periods under division (C) of this 1262  
section. 1263

(B) A health plan issuer shall not impose any preexisting 1264  
condition exclusion on any person. 1265

(C) (1) The superintendent of insurance shall adopt rules 1266  
to ensure that each individual health benefit plan has open 1267  
enrollment during a statewide open enrollment period to allow 1268  
individuals, including individuals who are not covered persons, 1269  
to enroll in the health benefit plan. 1270

(2) A health plan issuer shall provide special enrollment 1271  
periods for individuals who lose coverage as a result of a 1272  
qualifying event under 42 U.S.C. 9801(f) or 29 U.S.C. 1163. 1273

**Sec. 3902.53.** (A) For purposes of this section, "essential 1274  
health benefits package" means, with respect to a health benefit 1275  
plan, coverage that does all of the following: 1276

(1) Provides for the essential health benefits defined by 1277  
the superintendent of insurance under division (B) of this 1278  
section; 1279

(2) Limits cost sharing for such coverage in accordance 1280  
with division (C) of this section; 1281

(3) Provides the level of coverage described in division 1282  
(D) of this section. 1283

(B) (1) Subject to division (B) (2) of this section, the 1284  
superintendent shall define the essential health benefits, 1285  
except that such benefits shall include at least the following 1286  
general categories and the items and services covered within the 1287

<u>categories:</u>	1288
<u>(a) Ambulatory patient services;</u>	1289
<u>(b) Emergency services;</u>	1290
<u>(c) Hospitalization;</u>	1291
<u>(d) Maternity and newborn care;</u>	1292
<u>(e) Mental health and substance use disorder services,</u>	1293
<u>including behavioral health treatment;</u>	1294
<u>(f) Prescription drugs;</u>	1295
<u>(g) Rehabilitative and habilitative services and devices;</u>	1296
<u>(h) Laboratory services;</u>	1297
<u>(i) Preventive and wellness services and chronic disease</u>	1298
<u>management;</u>	1299
<u>(j) Pediatric services, including oral and vision care.</u>	1300
<u>(2) (a) The superintendent shall ensure that the scope of</u>	1301
<u>the essential health benefits under division (B) (1) of this</u>	1302
<u>section is equal to the scope of benefits provided under a</u>	1303
<u>typical employer plan, as determined by the superintendent. To</u>	1304
<u>inform this determination, the superintendent shall conduct a</u>	1305
<u>survey of employer-sponsored coverage to determine the benefits</u>	1306
<u>typically covered by employers, including multi-employer plans.</u>	1307
<u>(b) In defining the essential health benefits described in</u>	1308
<u>division (B) (1) of this section, and in revising the benefits</u>	1309
<u>under division (B) (3) (g) of this section, the superintendent</u>	1310
<u>shall submit a report to the general assembly containing a</u>	1311
<u>certification that such essential health benefits meet the</u>	1312
<u>requirements described in division (B) (2) (a) of this section.</u>	1313

(3) In defining the essential health benefits under 1314  
division (B)(1) of this section, the superintendent shall do all 1315  
of the following: 1316

(a) Ensure that such essential health benefits reflect an 1317  
appropriate balance among the categories described in division 1318  
(B)(1) of this section, so that benefits are not unduly weighted 1319  
toward any category; 1320

(b) Not make coverage decisions, determine reimbursement 1321  
rates, establish incentive programs, or design benefits in ways 1322  
that discriminate against individuals because of their age, 1323  
disability, or expected length of life; 1324

(c) Take into account the health care needs of diverse 1325  
segments of the population, including women, children, persons 1326  
with disabilities, and other groups; 1327

(d) Ensure that health benefits established as essential 1328  
not be subject to denial to individuals against their wishes on 1329  
the basis of the individuals' age or expected length of life or 1330  
of the individuals' present or predicted disability, degree of 1331  
medical dependency, or quality of life; 1332

(e) Provide that a qualified health benefit plan shall not 1333  
be treated as providing coverage for the essential health 1334  
benefits described in division (B)(1) of this section unless the 1335  
plan does both of the following: 1336

(i) Provides that coverage for emergency services, as 1337  
defined in section 3923.65 of the Revised Code, will be provided 1338  
without imposing any requirement under the plan for prior 1339  
authorization of services or any limitation on coverage where 1340  
the provider of services does not have a contractual 1341  
relationship with the plan for the providing of services that is 1342

more restrictive than the requirements or limitations that apply 1343  
to emergency services received from providers who do have such a 1344  
contractual relationship with the plan; 1345

(ii) Provides that if emergency services are provided out- 1346  
of-network, the cost-sharing requirement is the same requirement 1347  
that would apply if such services were provided in-network. 1348

(f) Periodically review the essential health benefits 1349  
under division (B) (1) of this section and provide a report to 1350  
the general assembly and the public that contains all of the 1351  
following: 1352

(i) An assessment of whether covered persons are facing 1353  
any difficulty accessing needed services for reasons of coverage 1354  
or cost; 1355

(ii) An assessment of whether the essential health 1356  
benefits needs to be modified or updated to account for changes 1357  
in medical evidence or scientific advancement; 1358

(iii) Information on how the essential health benefits 1359  
will be modified to address any such gaps in access or changes 1360  
in the evidence base; 1361

(iv) An assessment of the potential of additional or 1362  
expanded benefits to increase costs and the interactions between 1363  
the addition or expansion of benefits and reductions in existing 1364  
benefits to meet the requirements of division (B) (2) (a) of this 1365  
section. 1366

(g) Periodically update the essential health benefits 1367  
under division (B) (1) of this section to address any gaps in 1368  
access to coverage or changes in the evidence base the 1369  
superintendent identifies in the review conducted under division 1370  
(B) (3) (f) of this section. 1371

(4) Nothing in this section shall be construed to prohibit a health benefit plan from providing benefits in excess of the essential health benefits described in this section. 1372  
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(C) (1) A health plan issuer shall not require cost sharing in an amount greater than seven thousand nine hundred dollars for self-only coverage and fifteen thousand eight hundred dollars for other than self-only coverage for plan years beginning in 2020. 1375  
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(2) For plan years beginning in a calendar year after 2020, the cost-sharing limit shall be as follows: 1380  
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(a) In the case of self-only coverage, be equal to the dollar amount in division (C) (1) of this section, increased by the product of that amount and the premium adjustment percentage under division (C) (3) of this section for the calendar year; 1382  
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(b) In the case of other than self-only coverage, twice the amount in effect under division (C) (2) (a) of this section. If the amount of any increase under division (C) (2) (a) of this section is not a multiple of fifty dollars, such increase shall be rounded to the next lowest multiple of fifty dollars. 1386  
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(3) The premium adjustment percentage for any calendar year shall be the percentage by which the average per capita premium for health benefit plans in this state for the preceding calendar year, as estimated by the superintendent not later than the first day of October of such preceding calendar year, exceeds such average per capita premium for 2019, as determined by the superintendent. 1391  
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(D) (1) (a) Except as provided in division (D) (2) of this section, a health benefit plan shall provide a level of coverage that is designed to provide benefits that are actuarially 1398  
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equivalent to sixty per cent of the full actuarial value of the 1401  
benefits provided under the plan. 1402

(b) Under rules issued by the superintendent, the level of 1403  
coverage of a plan shall be determined on the basis that the 1404  
essential health benefits described in division (B)(1) of this 1405  
section shall be provided to a standard population, without 1406  
regard to the population the plan may actually provide benefits 1407  
to. 1408

(2) A health benefit plan that does not provide the level 1409  
of coverage described in division (D)(1) of this section shall 1410  
be considered as meeting the requirements of that division with 1411  
respect to any plan year if both of the following apply: 1412

(a) An individual is only eligible to enroll in the health 1413  
benefit plan if the individual meets either of the following 1414  
conditions: 1415

(i) The individual has not attained the age of thirty 1416  
before the beginning of the plan year. 1417

(ii) The individual meets a hardship exemption as 1418  
determined by the superintendent. 1419

(b) The health benefit plan provides both of the 1420  
following: 1421

(i) Except as provided in division (D)(2)(b)(ii) of this 1422  
section, the essential health benefits listed in division (B)(1) 1423  
of this section, except that the health benefit plan provides no 1424  
benefits for any plan year until the individual has incurred 1425  
cost-sharing expenses in an amount equal to the annual 1426  
limitation in effect under division (C) of this section for the 1427  
plan year except as provided for in section 3902.54 of the 1428  
Revised Code; 1429

<u>(ii) Coverage for at least three primary care visits.</u>	1430
<u>(3) If a health plan issuer offers a health benefit plan described in division (D) (2) of this section, the issuer shall only offer the plan in the individual market.</u>	1431 1432 1433
<u>(E) The requirements of this section do not apply to health benefit plans offered in the large group market.</u>	1434 1435
<u>(F) Nothing in this section is subject to the requirements of section 3901.71 of the Revised Code.</u>	1436 1437
<b><u>Sec. 3902.54.</u></b> (A) <u>A health benefit plan shall provide coverage for and shall not impose any cost-sharing requirements for the following:</u>	1438 1439 1440
<u>(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States preventive services task force;</u>	1441 1442 1443
<u>(2) Immunizations that have in effect a recommendation from the advisory committee on immunization practices of the United States centers for disease control and prevention with respect to the individual involved;</u>	1444 1445 1446 1447
<u>(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the United States health resources and services administration;</u>	1448 1449 1450 1451
<u>(4) With respect to women, such additional preventive care and screenings not described in division (A) (1) of this section as provided for in comprehensive guidelines supported by the United States health resources and services administration.</u>	1452 1453 1454 1455
<u>(B) The superintendent shall adopt rules to implement sections 3902.50 to 3902.54 of the Revised Code.</u>	1456 1457

<b>Sec. 3922.01.</b> As used in this chapter:	1458
(A) "Adverse benefit determination" means a decision by a health plan issuer:	1459 1460
(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:	1461 1462 1463
(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;	1464 1465 1466 1467 1468
(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;	1469 1470 1471 1472
(c) A determination that a health care service is not a covered benefit;	1473 1474
(d) The imposition of an exclusion, including exclusions for <del>pre-existing conditions</del> , source of injury, network, or any other limitation on benefits that would otherwise be covered.	1475 1476 1477
(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;	1478 1479 1480
(3) To rescind coverage on a health benefit plan.	1481
(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.	1482 1483
(C) "Authorized representative" means an individual who	1484

represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.

(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "Covered person" does not include the covered person's representative in any other context.

(F) "Covered benefits" or "benefits" means those health

care services to which a covered person is entitled under the 1512  
terms of a health benefit plan. 1513

(G) "Emergency medical condition" has the same meaning as 1514  
in section 1753.28 of the Revised Code. 1515

(H) "Emergency services" has the same meaning as in 1516  
section 1753.28 of the Revised Code. 1517

(I) "Evidence-based standard" means the conscientious, 1518  
explicit, and judicious use of the current best evidence, based 1519  
on a systematic review of the relevant research, in making 1520  
decisions about the care of individuals. 1521

(J) "Facility" means an institution providing health care 1522  
services, or a health care setting, including hospitals and 1523  
other licensed inpatient centers, ambulatory, surgical, 1524  
treatment, skilled nursing, residential treatment, diagnostic, 1525  
laboratory, and imaging centers, and rehabilitation and other 1526  
therapeutic health settings. 1527

(K) "Final adverse benefit determination" means an adverse 1528  
benefit determination that is upheld at the completion of a 1529  
health plan issuer's internal appeals process. 1530

(L) "Health benefit plan" means a policy, contract, 1531  
certificate, or agreement offered by a health plan issuer to 1532  
provide, deliver, arrange for, pay for, or reimburse any of the 1533  
costs of health care services, including benefit plans marketed 1534  
in the individual or group market by all associations, whether 1535  
bona fide or non-bona fide. "Health benefit plan" also means a 1536  
limited benefit plan, except as follows. "Health benefit plan" 1537  
does not mean any of the following types of coverage: a policy, 1538  
contract, certificate, or agreement that covers only a specified 1539  
accident, accident only, credit, dental, disability income, 1540

long-term care, hospital indemnity, supplemental coverage, as 1541  
described in section 3923.37 of the Revised Code, specified 1542  
disease, or vision care; coverage issued as a supplement to 1543  
liability insurance; insurance arising out of workers' 1544  
compensation or similar law; automobile medical payment 1545  
insurance; or insurance under which benefits are payable with or 1546  
without regard to fault and which is statutorily required to be 1547  
contained in any liability insurance policy or equivalent self- 1548  
insurance; a medicare supplement policy of insurance, as defined 1549  
by the superintendent of insurance by rule, coverage under a 1550  
plan through medicare, medicaid, or the federal employees 1551  
benefit program; any coverage issued under Chapter 55 of Title 1552  
10 of the United States Code and any coverage issued as a 1553  
supplement to that coverage. 1554

(M) "Health care professional" means a physician, 1555  
psychologist, nurse practitioner, or other health care 1556  
practitioner licensed, accredited, or certified to perform 1557  
health care services consistent with state law. 1558

(N) "Health care provider" or "provider" means a health 1559  
care professional or facility. 1560

(O) "Health care services" means services for the 1561  
diagnosis, prevention, treatment, cure, or relief of a health 1562  
condition, illness, injury, or disease. 1563

(P) "Health plan issuer" means an entity subject to the 1564  
insurance laws and rules of this state, or subject to the 1565  
jurisdiction of the superintendent of insurance, that contracts, 1566  
or offers to contract to provide, deliver, arrange for, pay for, 1567  
or reimburse any of the costs of health care services under a 1568  
health benefit plan, including a sickness and accident insurance 1569  
company, a health insuring corporation, a fraternal benefit 1570

society, a self-funded multiple employer welfare arrangement, or 1571  
a nonfederal, government health plan. "Health plan issuer" 1572  
includes a third party administrator licensed under Chapter 1573  
3959. of the Revised Code to the extent that the benefits that 1574  
such an entity is contracted to administer under a health 1575  
benefit plan are subject to the insurance laws and rules of this 1576  
state or subject to the jurisdiction of the superintendent. 1577

(Q) "Health information" means information or data, 1578  
whether oral or recorded in any form or medium, and personal 1579  
facts or information about events or relationships that relates 1580  
to all of the following: 1581

(1) The past, present, or future physical, mental, or 1582  
behavioral health or condition of a covered person or a member 1583  
of the covered person's family; 1584

(2) The provision of health care services or health- 1585  
related benefits to a covered person; 1586

(3) Payment for the provision of health care services to 1587  
or for a covered person. 1588

(R) "Independent review organization" means an entity that 1589  
is accredited to conduct independent external reviews of adverse 1590  
benefit determinations pursuant to section 3922.13 of the 1591  
Revised Code. 1592

(S) "Medical or scientific evidence" means evidence found 1593  
in any of the following sources: 1594

(1) Peer-reviewed scientific studies published in, or 1595  
accepted for publication by, medical journals that meet 1596  
nationally recognized requirements for scientific manuscripts 1597  
and that submit most of their published articles for review by 1598  
experts who are not part of the editorial staff; 1599

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus;	1600 1601 1602 1603 1604 1605 1606
(3) Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the federal social security act;	1607 1608 1609
(4) The following standard reference compendia:	1610
(a) The American hospital formulary service drug information;	1611 1612
(b) Drug facts and comparisons;	1613
(c) The American dental association accepted dental therapeutics;	1614 1615
(d) The United States pharmacopoeia drug information.	1616
(5) Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:	1617 1618 1619 1620
(a) The federal agency for health care research and quality;	1621 1622
(b) The national institutes of health;	1623
(c) The national cancer institute;	1624
(d) The national academy of sciences;	1625
(e) The centers for medicare and medicaid services;	1626

(f) The federal food and drug administration;	1627
(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.	1628 1629 1630
(6) Any other medical or scientific evidence that is comparable.	1631 1632
(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.	1633 1634
(U) "Protected health information" means health information related to the identity of an individual, or information that could reasonably be used to determine the identity of an individual.	1635 1636 1637 1638
(V) "Rescind" means to retroactively cancel or discontinue coverage. "Rescind" does not include canceling or discontinuing coverage that only has a prospective effect or canceling or discontinuing coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.	1639 1640 1641 1642 1643 1644
(W) "Retrospective review" means a review conducted after services have been provided to a covered person.	1645 1646
(X) "Superintendent" means the superintendent of insurance.	1647 1648
(Y) "Utilization review" has the same meaning as in section 1751.77 of the Revised Code.	1649 1650
(Z) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.	1651 1652
<b>Sec. 3923.122.</b> (A) Every policy of group sickness and	1653

accident insurance providing hospital, surgical, or medical 1654  
expense coverage for other than specific diseases or accidents 1655  
only, and delivered, issued for delivery, or renewed in this 1656  
state on or after January 1, 1976, shall include a provision 1657  
giving each insured the option to convert to ~~the following:~~ 1658

~~(1) In the case of an individual who is not a federally 1659  
eligible individual,~~ any of the individual policies of hospital, 1660  
surgical, or medical expense insurance then being issued by the 1661  
insurer with benefit limits not to exceed those in effect under 1662  
the group policy. 1663

~~(2) In the case of a federally eligible individual, a 1664  
basic or standard plan established in accordance with section 1665  
3924.10 of the Revised Code or plans substantially similar to 1666  
the basic and standard plan in benefit design and scope of 1667  
covered services. For purposes of division (A) (2) of this 1668  
section, the superintendent of insurance shall determine whether 1669  
a plan is substantially similar to the basic or standard plan in 1670  
benefit design and scope of covered services. 1671~~

(B) An option for conversion to an individual policy shall 1672  
be available without evidence of insurability to every insured, 1673  
including any person eligible under division (D) of this 1674  
section, who terminates employment or membership in the group 1675  
holding the policy after having been continuously insured 1676  
thereunder for at least one year. 1677

Upon receipt of the insured's written application and upon 1678  
payment of at least the first quarterly premium not later than 1679  
thirty-one days after the termination of coverage under the 1680  
group policy, the insurer shall issue a converted policy on a 1681  
form then available for conversion. The premium shall be in 1682  
accordance with the insurer's table of premium rates in effect 1683

on the later of the following dates: 1684

(1) The effective date of the converted policy; 1685

(2) The date of application therefor; and shall be 1686  
applicable to the class of risk to which each person covered 1687  
belongs and to the form and amount of the policy at the person's 1688  
then attained age. ~~However, premiums charged federally eligible~~ 1689  
~~individuals may not exceed the amounts specified below:~~ 1690

~~(a) For calendar years 2010 and 2011, an amount that is~~ 1691  
~~two times the base rate charged any other individual of a group~~ 1692  
~~to which the insurer is currently accepting new business and for~~ 1693  
~~which similar copayments and deductibles are applied;~~ 1694

~~(b) For calendar year 2012 and every year thereafter, an~~ 1695  
~~amount that is one and one half times the base rate charged any~~ 1696  
~~other individual of a group to which the insurer is currently~~ 1697  
~~accepting new business and for which similar copayments and~~ 1698  
~~deductibles are applied, unless the superintendent of insurance~~ 1699  
~~determines that the amendments by this act to sections 3923.58~~ 1700  
~~and 3923.581 of the Revised Code, have resulted in the market~~ 1701  
~~wide average medical loss ratio for coverage sold to individual~~ 1702  
~~insureds and nonemployer group insureds in this state, including~~ 1703  
~~open enrollment insureds, to increase by more than five and one~~ 1704  
~~quarter percentage points during calendar year 2010. If the~~ 1705  
~~superintendent makes that determination, the premium limit~~ 1706  
~~established by division (B) (2) (a) of this section shall remain~~ 1707  
~~in effect.~~ 1708

At the election of the insurer, a separate converted 1709  
policy may be issued to cover any dependent of an employee or 1710  
member of the group. 1711

Except as provided in division (H) of this section, any 1712

converted policy shall become effective as of the day following 1713  
the date of termination of insurance under the group policy. 1714

Any probationary or waiting period set forth in the 1715  
converted policy is deemed to commence on the effective date of 1716  
the insured's coverage under the group policy. 1717

(C) No insurer shall be required to issue a converted 1718  
policy to any person who is, or is eligible to be, covered for 1719  
benefits at least comparable to the group policy under: 1720

(1) Title XVIII of the Social Security Act, as amended or 1721  
superseded; 1722

(2) Any act of congress or law under this or any other 1723  
state of the United States that duplicates coverage offered 1724  
under division (C)(1) of this section; 1725

(3) Any policy that duplicates coverage offered under 1726  
division (C)(1) of this section; 1727

(4) Any other group sickness and accident insurance 1728  
providing hospital, surgical, or medical expense coverage for 1729  
other than specific diseases or accidents only. 1730

(D) The option for conversion shall be available: 1731

(1) Upon the death of the employee or member, to the 1732  
surviving spouse with respect to such of the spouse and 1733  
dependents as are then covered by the group policy; 1734

(2) To a child solely with respect to the child upon 1735  
attaining the limiting age of coverage under the group policy 1736  
while covered as a dependent thereunder; 1737

(3) Upon the divorce, dissolution, or annulment of the 1738  
marriage of the employee or member, to the divorced spouse, or 1739

former spouse in the event of annulment, of such employee or 1740  
member, or upon the legal separation of the spouse from such 1741  
employee or member, to the spouse. 1742

Persons possessing the option for conversion pursuant to 1743  
this division shall be considered members for the purposes of 1744  
division (H) of this section. 1745

(E) If coverage is continued under a group policy on an 1746  
employee following retirement prior to the time the employee is, 1747  
or is eligible to be, covered by Title XVIII of the Social 1748  
Security Act, the employee may elect, in lieu of the continuance 1749  
of group insurance, to have the same conversion rights as would 1750  
apply had the employee's insurance terminated at retirement by 1751  
reason of termination of employment. 1752

(F) If the insurer and the group policyholder agree upon 1753  
one or more additional plans of benefits to be available for 1754  
converted policies, the applicant for the converted policy may 1755  
elect such a plan in lieu of a converted policy. 1756

(G) The converted policy may contain provisions for 1757  
avoiding duplication of benefits provided pursuant to divisions 1758  
(C) (1), (2), (3), and (4) of this section or provided under any 1759  
other insured or noninsured plan or program. 1760

(H) If an employee or member becomes entitled to obtain a 1761  
converted policy pursuant to this section, and if the employee 1762  
or member has not received notice of the conversion privilege at 1763  
least fifteen days prior to the expiration of the thirty-one-day 1764  
conversion period provided in division (B) of this section, then 1765  
the employee or member has an additional period within which to 1766  
exercise the privilege. This additional period shall expire 1767  
fifteen days after the employee or member receives notice, but 1768

in no event shall the period extend beyond sixty days after the 1769  
expiration of the thirty-one-day conversion period. 1770

Written notice presented to the employee or member, or 1771  
mailed by the policyholder to the last known address of the 1772  
employee or member as indicated on its records, constitutes 1773  
notice for the purpose of this division. In the case of a person 1774  
who is eligible for a converted policy under division (D) (2) or 1775  
(D) (3) of this section, a policyholder shall not be responsible 1776  
for presenting or mailing such notice, unless such policyholder 1777  
has actual knowledge of the person's eligibility for a converted 1778  
policy. 1779

If an additional period is allowed by an employee or 1780  
member for the exercise of a conversion privilege, and if 1781  
written application for the converted policy, accompanied by at 1782  
least the first quarterly premium, is made after the expiration 1783  
of the thirty-one-day conversion period, but within the 1784  
additional period allowed an employee or member in accordance 1785  
with this division, the effective date of the converted policy 1786  
shall be the date of application. 1787

(I) The converted policy may provide that any hospital, 1788  
surgical, or medical expense benefits otherwise payable with 1789  
respect to any person may be reduced by the amount of any such 1790  
benefits payable under the group policy for the same loss after 1791  
termination of coverage. 1792

(J) The converted policy may contain: 1793

(1) Any exclusion, reduction, or limitation contained in 1794  
the group policy or customarily used in individual policies 1795  
issued by the insurer; 1796

(2) Any provision permitted in this section; 1797

(3) Any other provision not prohibited by law.	1798
Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider.	1799 1800 1801
(K) The time limit specified in a converted policy for certain defenses with respect to any person who was covered by a group policy shall commence on the effective date of such person's coverage under the group policy.	1802 1803 1804 1805
(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy.	1806 1807
(M) No insurer shall use age or health status as the basis for refusing to renew a converted policy.	1808 1809
(N) A converted policy made available pursuant to this section shall, if delivery of the policy is to be made in this state, comply with this section. If delivery of a converted policy is to be made in another state, it may be on a form offered by the insurer in the jurisdiction where the delivery is to be made and which provides benefits substantially in compliance with those required in a policy delivered in this state.	1810 1811 1812 1813 1814 1815 1816 1817
<del>(O) As used in this section:</del>	1818
<del>(1) "Base rate" means, as to any health benefit plan that is issued by an insurer in the individual market, the lowest premium rate for new or existing business prescribed by the insurer for the same or similar coverage under a plan or arrangement covering any individual of a group with similar case characteristics.</del>	1819 1820 1821 1822 1823 1824
<del>(2) "Federally eligible individual" means an eligible</del>	1825

~~individual as defined in 45 C.F.R. 148.103.~~ 1826

**Sec. 3923.57.** Notwithstanding any provision of this 1827  
chapter, every individual policy of sickness and accident 1828  
insurance that is delivered, issued for delivery, or renewed in 1829  
this state is subject to the following conditions, as 1830  
applicable: 1831

~~(A) Pre-existing conditions provisions shall not exclude~~ 1832  
~~or limit coverage for a period beyond twelve months following~~ 1833  
~~the policyholder's effective date of coverage and may only~~ 1834  
~~relate to conditions during the six months immediately preceding~~ 1835  
~~the effective date of coverage.~~ 1836

~~(B) In determining whether a pre-existing conditions~~ 1837  
~~provision applies to a policyholder or dependent, each policy~~ 1838  
~~shall credit the time the policyholder or dependent was covered~~ 1839  
~~under a previous policy, contract, or plan if the previous~~ 1840  
~~coverage was continuous to a date not more than thirty days~~ 1841  
~~prior to the effective date of the new coverage, exclusive of~~ 1842  
~~any applicable service waiting period under the policy.~~ 1843

~~(C)~~ (1) Except as otherwise provided in division ~~(C)~~ (A) of 1844  
this section, an insurer that provides an individual sickness 1845  
and accident insurance policy to an individual shall renew or 1846  
continue in force such coverage at the option of the individual. 1847

(2) An insurer may nonrenew or discontinue coverage of an 1848  
individual in the individual market based only on one or more of 1849  
the following reasons: 1850

(a) The individual failed to pay premiums or contributions 1851  
in accordance with the terms of the policy or the insurer has 1852  
not received timely premium payments. 1853

(b) The individual performed an act or practice that 1854

constitutes fraud or made an intentional misrepresentation of 1855  
material fact under the terms of the policy. 1856

(c) The insurer is ceasing to offer coverage in the 1857  
individual market in accordance with division ~~(D)~~ (B) of this 1858  
section and the applicable laws of this state. 1859

(d) If the insurer offers coverage in the market through a 1860  
network plan, the individual no longer resides, lives, or works 1861  
in the service area, or in an area for which the insurer is 1862  
authorized to do business; provided, however, that such coverage 1863  
is terminated uniformly without regard to any health status- 1864  
related factor of covered individuals. 1865

(e) If the coverage is made available in the individual 1866  
market only through one or more bona fide associations, the 1867  
membership of the individual in the association, on the basis of 1868  
which the coverage is provided, ceases; provided, however, that 1869  
such coverage is terminated under division ~~(C)~~ (A) (2) (e) of this 1870  
section uniformly without regard to any health status-related 1871  
factor of covered individuals. 1872

~~An insurer offering coverage to individuals solely through 1873  
membership in a bona fide association shall not be deemed, by 1874  
virtue of that offering, to be in the individual market for 1875  
purposes of sections 3923.58 and 3923.581 of the Revised Code. 1876  
Such an insurer shall not be required to accept applicants for 1877  
coverage in the individual market pursuant to sections 3923.58 1878  
and 3923.581 of the Revised Code unless the insurer also offers 1879  
coverage to individuals other than through bona fide 1880  
associations. 1881~~

(3) An insurer may cancel or decide not to renew the 1882  
coverage of a dependent of an individual if the dependent has 1883

performed an act or practice that constitutes fraud or made an 1884  
intentional misrepresentation of material fact under the terms 1885  
of the coverage and if the cancellation or nonrenewal is not 1886  
based, either directly or indirectly, on any health status- 1887  
related factor in relation to the dependent. 1888

~~(D)~~(B)(1) If an insurer decides to discontinue offering a 1889  
particular type of health insurance coverage offered in the 1890  
individual market, coverage of such type may be discontinued by 1891  
the insurer if the insurer does all of the following: 1892

(a) Provides notice to each individual provided coverage 1893  
of this type in such market of the discontinuation at least 1894  
ninety days prior to the date of the discontinuation of the 1895  
coverage; 1896

(b) Offers to each individual provided coverage of this 1897  
type in such market, the option to purchase any other individual 1898  
health insurance coverage currently being offered by the insurer 1899  
for individuals in that market; 1900

(c) In exercising the option to discontinue coverage of 1901  
this type and in offering the option of coverage under division 1902  
~~(D)~~(B)(1)(b) of this section, acts uniformly without regard to 1903  
any health status-related factor of covered individuals or of 1904  
individuals who may become eligible for such coverage. 1905

(2) If an insurer elects to discontinue offering all 1906  
health insurance coverage in the individual market in this 1907  
state, health insurance coverage may be discontinued by the 1908  
insurer only if both of the following apply: 1909

(a) The insurer provides notice to the department of 1910  
insurance and to each individual of the discontinuation at least 1911  
one hundred eighty days prior to the date of the expiration of 1912

the coverage. 1913

(b) All health insurance delivered or issued for delivery 1914  
in this state in such market is discontinued and coverage under 1915  
that health insurance in that market is not renewed. 1916

(3) In the event of a discontinuation under division ~~(D)~~ 1917  
(B) (2) of this section in the individual market, the insurer 1918  
shall not provide for the issuance of any health insurance 1919  
coverage in the market and this state during the five-year 1920  
period beginning on the date of the discontinuation of the last 1921  
health insurance coverage not so renewed. 1922

~~(E)~~ (C) Notwithstanding divisions ~~(C)~~ (A) and ~~(D)~~ (B) of 1923  
this section, an insurer may, at the time of coverage renewal, 1924  
modify the health insurance coverage for a policy form offered 1925  
to individuals in the individual market if the modification is 1926  
consistent with the law of this state and effective on a uniform 1927  
basis among all individuals with that policy form. 1928

~~(F)~~ (D) Such policies are subject to sections 2743 and 1929  
2747 of the "Health Insurance Portability and Accountability Act 1930  
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1931  
300gg-43 and 300gg-47, as amended. 1932

~~(G)~~ (E) Sections 3924.031 and 3924.032 of the Revised Code 1933  
shall apply to sickness and accident insurance policies offered 1934  
in the individual market in the same manner as they apply to 1935  
health benefit plans offered in the small employer market. 1936

In accordance with 45 C.F.R. 148.102, divisions ~~(C)~~ (A) to 1937  
~~(G)~~ (E) of this section also apply to all group sickness and 1938  
accident insurance policies that are not sold in connection with 1939  
an employment-related group health plan and that provide more 1940  
than short-term, limited duration coverage. 1941

In applying divisions ~~(C)~~(A) to ~~(G)~~(E) of this section 1942  
with respect to health insurance coverage that is made available 1943  
by an insurer in the individual market to individuals only 1944  
through one or more associations, the term "individual" includes 1945  
the association of which the individual is a member. 1946

For purposes of this section, any policy issued pursuant 1947  
to division (C) of section 3923.13 of the Revised Code in 1948  
connection with a public or private college or university 1949  
student health insurance program is considered to be issued to a 1950  
bona fide association. 1951

As used in this section, "bona fide association" has the 1952  
same meaning as in section 3924.03 of the Revised Code, and 1953  
"health status-related factor" and "network plan" have the same 1954  
meanings as in section 3924.031 of the Revised Code. 1955

This section does not apply to any policy that provides 1956  
coverage for specific diseases or accidents only, or to any 1957  
hospital indemnity, medicare supplement, long-term care, 1958  
disability income, one-time-limited-duration policy that is less 1959  
than twelve months, or other policy that offers only 1960  
supplemental benefits. 1961

**Sec. 3923.571.** Except as otherwise provided in section 1962  
2721 of the "Health Insurance Portability and Accountability Act 1963  
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1964  
300gg-21, as amended, the following conditions apply to all 1965  
group policies of sickness and accident insurance that are sold 1966  
in connection with an employment-related group health plan and 1967  
that are not subject to section 3924.03 of the Revised Code: 1968

(A) Any such policy shall comply with the requirements of 1969  
~~division (A) of section 3924.03 and section 3924.033 of the~~ 1970

Revised Code. 1971

(B) (1) Except as provided in section 2712(b) to (e) of the 1972  
"Health Insurance Portability and Accountability Act of 1996," 1973  
if an insurer offers coverage in the small or large group market 1974  
in connection with a group policy, the insurer shall renew or 1975  
continue in force such coverage at the option of the 1976  
policyholder. 1977

(2) An insurer may cancel or decide not to renew the 1978  
coverage of an employee or of a dependent of an employee if the 1979  
employee or dependent, as applicable, has performed an act or 1980  
practice that constitutes fraud or made an intentional 1981  
misrepresentation of material fact under the terms of the 1982  
coverage and if the cancellation or nonrenewal is not based, 1983  
either directly or indirectly, on any health status-related 1984  
factor in relation to the employee or dependent. 1985

As used in division (B) (2) of this section, "health 1986  
status-related factor" has the same meaning as in section 1987  
3924.031 of the Revised Code. 1988

(C) (1) No such policy, or insurer offering health 1989  
insurance coverage in connection with such a policy, shall 1990  
require any individual, as a condition of coverage or continued 1991  
coverage under the policy, to pay a premium or contribution that 1992  
is greater than the premium or contribution for a similarly 1993  
situated individual covered under the policy on the basis of any 1994  
health status-related factor in relation to the individual or to 1995  
an individual covered under the policy as a dependent of the 1996  
individual. 1997

(2) Nothing in division (C) (1) of this section shall be 1998  
construed to restrict the amount that an employer may be charged 1999

for coverage under a group policy, or to prevent a group policy, 2000  
and an insurer offering group health insurance coverage, from 2001  
establishing premium discounts or rebates or modifying otherwise 2002  
applicable copayments or deductibles in return for adherence to 2003  
programs of health promotion and disease prevention. 2004

(D) Such policies shall provide for the special enrollment 2005  
periods described in section 2701(f) of the "Health Insurance 2006  
Portability and Accountability Act of 1996." 2007

(E) At least once in every twelve-month period, an insurer 2008  
shall provide to all late enrollees, as defined in section 2009  
3924.01 of the Revised Code, who are identified by the 2010  
policyholder, the option to enroll in the group policy. The 2011  
enrollment option shall be provided for a minimum period of 2012  
thirty consecutive days. All delays of coverage imposed under 2013  
the group policy, including any pre-existing condition exclusion 2014  
period or service waiting period, shall begin on the date the 2015  
insurer receives notice of the late enrollee's application or 2016  
request for coverage, and shall run concurrently with each 2017  
other. 2018

**Sec. 3923.85.** (A) As used in this section, "cost sharing" 2019  
means the cost to an individual insured under an individual or 2020  
group policy of sickness and accident insurance or a public 2021  
employee benefit plan according to any coverage limit, 2022  
copayment, coinsurance, deductible, or other out-of-pocket 2023  
expense requirements imposed by the policy or plan. 2024

(B) Notwithstanding section 3901.71 of the Revised Code 2025  
and subject to division (D) of this section, no individual or 2026  
group policy of sickness and accident insurance that is 2027  
delivered, issued for delivery, or renewed in this state and no 2028  
public employee benefit plan that is established or modified in 2029

this state shall fail to comply with either of the following: 2030

(1) The policy or plan shall not provide coverage or 2031  
impose cost sharing for a prescribed, orally administered cancer 2032  
medication on a less favorable basis than the coverage it 2033  
provides or cost sharing it imposes for intravenously 2034  
administered or injected cancer medications. 2035

(2) The policy or plan shall not comply with division (B) 2036  
(1) of this section by imposing an increase in cost sharing 2037  
solely for orally administered, intravenously administered, or 2038  
injected cancer medications. 2039

(C) Notwithstanding any provision of this section to the 2040  
contrary, a policy or plan shall be deemed to be in compliance 2041  
with this section if the cost sharing imposed under such a 2042  
policy or plan for orally administered cancer treatments does 2043  
not exceed one hundred dollars per prescription fill. The cost\_ 2044  
sharing limit of one hundred dollars per prescription fill shall 2045  
apply to a high deductible plan, as defined in 26 U.S.C. 223, or 2046  
a catastrophic plan, described in division (D) (2) of section 2047  
3902.53 of the Revised Code and as defined in 42 U.S.C. 18022, 2048  
only after the deductible has been met. 2049

(D) (1) The prohibitions in division (B) of this section do 2050  
not preclude an individual or group policy of sickness and 2051  
accident insurance or public employee benefit plan from 2052  
requiring an insured or plan member to obtain prior 2053  
authorization before orally administered cancer medication is 2054  
dispensed to the insured or plan member. 2055

(2) Division (B) of this section does not apply to the 2056  
offer or renewal of any individual or group policy of sickness 2057  
and accident insurance that provides coverage for specific 2058

diseases or accidents only, or to any hospital indemnity, 2059  
medicare supplement, disability income, or other policy that 2060  
offers only supplemental benefits. 2061

(E) An insurer that offers any sickness and accident 2062  
insurance or any public employee benefit plan that offers 2063  
coverage for basic health care services is not required to 2064  
comply with division (B) of this section if all of the following 2065  
apply: 2066

(1) The insurer or plan submits documentation certified by 2067  
an independent member of the American academy of actuaries to 2068  
the superintendent of insurance showing that compliance with 2069  
division (B)(1) of this section for a period of at least six 2070  
months independently caused the insurer or plan's costs for 2071  
claims and administrative expenses for the coverage of basic 2072  
health care services to increase by more than one per cent per 2073  
year. 2074

(2) The insurer or plan submits a signed letter from an 2075  
independent member of the American academy of actuaries to the 2076  
superintendent of insurance opining that the increase in costs 2077  
described in division (E)(1) of this section could reasonably 2078  
justify an increase of more than one per cent in the annual 2079  
premiums or rates charged by the insurer or plan for the 2080  
coverage of basic health care services. 2081

(3)(a) The superintendent of insurance makes the following 2082  
determinations from the documentation and opinion submitted 2083  
pursuant to divisions (E)(1) and (2) of this section: 2084

(i) Compliance with division (B)(1) of this section for a 2085  
period of at least six months independently caused the insurer 2086  
or plan's costs for claims and administrative expenses for the 2087

coverage of basic health care services to increase more than one 2088  
per cent per year. 2089

(ii) The increase in costs reasonably justifies an 2090  
increase of more than one per cent in the annual premiums or 2091  
rates charged by the insurer or plan for the coverage of basic 2092  
health care services. 2093

(b) Any determination made by the superintendent under 2094  
division (E) (3) of this section is subject to Chapter 119. of 2095  
the Revised Code. 2096

**Sec. 3924.01.** As used in sections 3924.01 to ~~3924.14~~ 2097  
3924.06 of the Revised Code: 2098

(A) "Actuarial certification" means a written statement 2099  
prepared by a member of the American academy of actuaries, or by 2100  
any other person acceptable to the superintendent of insurance, 2101  
that states that, based upon the person's examination, a carrier 2102  
offering health benefit plans to small employers is in 2103  
compliance with sections 3924.01 to ~~3924.14~~ 3924.06 of the 2104  
Revised Code. "Actuarial certification" shall include a review 2105  
of the appropriate records of, and the actuarial assumptions and 2106  
methods used by, the carrier relative to establishing premium 2107  
rates for the health benefit plans. 2108

(B) ~~"Adjusted average market premium price" means the~~ 2109  
~~average market premium price as determined by the board of~~ 2110  
~~directors of the Ohio health reinsurance program either on the~~ 2111  
~~basis of the arithmetic mean of all carriers' premium rates for~~ 2112  
~~an OHC plan sold to groups with similar case characteristics by~~ 2113  
~~all carriers selling OHC plans in the state, or on any other~~ 2114  
~~equitable basis determined by the board.~~ 2115

~~(C)~~ "Base premium rate" means, as to any health benefit 2116

plan that is issued by a carrier and that covers at least two 2117  
but no more than fifty employees of a small employer, the lowest 2118  
premium rate for a new or existing business prescribed by the 2119  
carrier for the same or similar coverage under a plan or 2120  
arrangement covering any small employer with similar case 2121  
characteristics. 2122

~~(D)~~ (C) "Carrier" means any sickness and accident 2123  
insurance company or health insuring corporation authorized to 2124  
issue health benefit plans in this state or a MEWA. A sickness 2125  
and accident insurance company that owns or operates a health 2126  
insuring corporation, either as a separate corporation or as a 2127  
line of business, shall be considered as a separate carrier from 2128  
that health insuring corporation for purposes of sections 2129  
3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. 2130

~~(E)~~ (D) "Case characteristics" means, with respect to a 2131  
small employer, the geographic area in which the employees work; 2132  
the age and sex of the individual employees and their 2133  
dependents; the appropriate industry classification as 2134  
determined by the carrier; the number of employees and 2135  
dependents; and such other objective criteria as may be 2136  
established by the carrier. "Case characteristics" does not 2137  
include claims experience, health status, or duration of 2138  
coverage from the date of issue. 2139

~~(F)~~ (E) "Dependent" means the spouse or child of an 2140  
eligible employee, subject to applicable terms of the health 2141  
benefits plan covering the employee. 2142

~~(G)~~ (F) "Eligible employee" means an employee who works a 2143  
normal work week of thirty or more hours. "Eligible employee" 2144  
does not include a temporary or substitute employee, or a 2145  
seasonal employee who works only part of the calendar year on 2146

the basis of natural or suitable times or circumstances. 2147

~~(H)~~ (G) "Health benefit plan" means any hospital or 2148  
medical expense policy or certificate or any health plan 2149  
provided by a carrier, that is delivered, issued for delivery, 2150  
renewed, or used in this state on or after the date occurring 2151  
six months after November 24, 1995. "Health benefit plan" does 2152  
not include policies covering only accident, credit, dental, 2153  
disability income, long-term care, hospital indemnity, medicare 2154  
supplement, specified disease, or vision care; coverage under a 2155  
one-time-limited-duration policy that is less than twelve 2156  
months; coverage issued as a supplement to liability insurance; 2157  
insurance arising out of a workers' compensation or similar law; 2158  
automobile medical-payment insurance; or insurance under which 2159  
benefits are payable with or without regard to fault and which 2160  
is statutorily required to be contained in any liability 2161  
insurance policy or equivalent self-insurance. 2162

~~(I)~~ (H) "Late enrollee" means an eligible employee or 2163  
dependent who enrolls in a small employer's health benefit plan 2164  
other than during the first period in which the employee or 2165  
dependent is eligible to enroll under the plan or during a 2166  
special enrollment period described in section 2701(f) of the 2167  
"Health Insurance Portability and Accountability Act of 1996," 2168  
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as 2169  
amended. 2170

~~(J)~~ (I) "MEWA" means any "multiple employer welfare 2171  
arrangement" as defined in section 3 of the "Federal Employee 2172  
Retirement Income Security Act of 1974," 88 Stat. 832, 29 2173  
U.S.C.A. 1001, as amended, except for any arrangement which is 2174  
fully insured as defined in division (b) (6) (D) of section 514 of 2175  
that act. 2176

~~(K)~~ (J) "Midpoint rate" means, for small employers with 2177  
similar case characteristics and plan designs and as determined 2178  
by the applicable carrier for a rating period, the arithmetic 2179  
average of the applicable base premium rate and the 2180  
corresponding highest premium rate. 2181

~~(L)~~ "Pre-existing conditions provision" means a policy 2182  
~~provision that excludes or limits coverage for charges or~~ 2183  
~~expenses incurred during a specified period following the~~ 2184  
~~insured's enrollment date as to a condition for which medical~~ 2185  
~~advice, diagnosis, care, or treatment was recommended or~~ 2186  
~~received during a specified period immediately preceding the~~ 2187  
~~enrollment date. Genetic information shall not be treated as~~ 2188  
~~such a condition in the absence of a diagnosis of the condition~~ 2189  
~~related to such information.~~ 2190

~~For purposes of this division, "enrollment date" means,~~ 2191  
~~with respect to an individual covered under a group health~~ 2192  
~~benefit plan, the date of enrollment of the individual in the~~ 2193  
~~plan or, if earlier, the first day of the waiting period for~~ 2194  
~~such enrollment.~~ 2195

~~(M)~~ (K) "Service waiting period" means the period of time 2196  
after employment begins before an employee is eligible to be 2197  
covered for benefits under the terms of any applicable health 2198  
benefit plan offered by the small employer. 2199

~~(N)~~ (L) (1) "Small employer" means, in connection with a 2200  
group health benefit plan and with respect to a calendar year 2201  
and a plan year, an employer who employed an average of at least 2202  
two but no more than fifty eligible employees on business days 2203  
during the preceding calendar year and who employs at least two 2204  
employees on the first day of the plan year. 2205

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

~~(O) "OHC plan" means an Ohio health care plan, which is the basic, standard, or carrier reimbursement plan for small employers and individuals established in accordance with section 3924.10 of the Revised Code.~~

**Sec. 3924.02.** (A) An individual or group health benefit plan is subject to sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code if it provides health care benefits covering at least two but no more than fifty employees of a small employer, and if it meets either of the following conditions:

(1) Any portion of the premium or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The health benefit plan is treated by the employer or  
any of the covered individuals as part of a plan or program for  
purposes of section 106 or 162 of the "Internal Revenue Code of  
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(B) Notwithstanding division (A) of this section,  
divisions ~~(D)~~(C), ~~(E)~~(D)(2), ~~(F)~~(E), and ~~(G)~~(F) of section  
3924.03 of the Revised Code and section 3924.04 of the Revised  
Code do not apply to health benefit policies that are not sold  
to owners of small businesses as an employment benefit plan.  
Such policies shall clearly state that they are not being sold  
as an employment benefit plan and that the owner of the business  
is not responsible, either directly or indirectly, for paying  
the premium or benefits.

(C) Every health benefit plan offered or delivered by a  
carrier, other than a health insuring corporation, to a small  
employer is subject to sections 3923.23, 3923.231, 3923.232,  
3923.233, and 3923.234 of the Revised Code and any other  
provision of the Revised Code that requires the reimbursement,  
utilization, or consideration of a specific category of a  
licensed or certified health care practitioner.

(D) Except as expressly provided in sections 3924.01 to  
~~3924.14~~3924.06 of the Revised Code, no health benefit plan  
offered to a small employer is subject to any of the following:

(1) Any law that would inhibit any carrier from  
contracting with providers or groups of providers with respect  
to health care services or benefits;

(2) Any law that would impose any restriction on the  
ability to negotiate with providers regarding the level or  
method of reimbursing care or services provided under the health

benefit plan; 2265

(3) Any law that would require any carrier to either 2266  
include a specific provider or class of provider when 2267  
contracting for health care services or benefits, or to exclude 2268  
any class of provider that is generally authorized by statute to 2269  
provide such care. 2270

**Sec. 3924.03.** Except as otherwise provided in section 2721 2271  
of the "Health Insurance Portability and Accountability Act of 2272  
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg- 2273  
21, as amended, health benefit plans covering small employers 2274  
are subject to the following conditions, as applicable: 2275

~~(A) (1) Pre-existing conditions provisions shall not 2276  
exclude or limit coverage for a period beyond twelve months, or 2277  
eighteen months in the case of a late enrollee, following the 2278  
individual's enrollment date and may only relate to a physical 2279  
or mental condition, regardless of the cause of the condition, 2280  
for which medical advice, diagnosis, care, or treatment was 2281  
recommended or received within the six months immediately 2282  
preceding the enrollment date. 2283~~

~~Division (A) (1) of this section is subject to the 2284  
exceptions set forth in section 2701(d) of the "Health Insurance 2285  
Portability and Accountability Act of 1996." 2286~~

~~(2) The period of any such pre-existing condition 2287  
exclusion shall be reduced by the aggregate of the periods of 2288  
creditable coverage, if any, applicable to the employee or 2289  
dependent as of the enrollment date. 2290~~

~~(3) A period of creditable coverage shall not be counted, 2291  
with respect to enrollment of an individual under a group health 2292  
benefit plan, if, after that period and before the enrollment 2293~~

~~date, there was a sixty three day period during all of which the individual was not covered under any creditable coverage.~~ 2294  
2295  
~~Subsections (c) (2) to (4) and (e) of section 2701 of the "Health Insurance Portability and Accountability Act of 1996" apply with respect to crediting previous coverage.~~ 2296  
2297  
2298

~~(4) As used in division (A) of this section:~~ 2299

~~(a) "Creditable coverage" has the same meaning as in section 2701(c) (1) of the "Health Insurance Portability and Accountability Act of 1996."~~ 2300  
2301  
2302

~~(b) "Enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.~~ 2303  
2304  
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~~(B) (1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a carrier offers coverage in the small employer market in connection with a group health benefit plan, the carrier shall renew or continue in force such coverage at the option of the plan sponsor of the plan.~~ 2307  
2308  
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(2) A carrier may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee if the employee or dependent, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the employee or dependent. 2313  
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As used in division ~~(B)~~ (A) (2) of this section, "health status-related factor" has the same meaning as in section 2321  
2322

3924.031 of the Revised Code. 2323

~~(C)~~ (B) A carrier shall not exclude any eligible employee 2324  
or dependent, who would otherwise be covered under a health 2325  
benefit plan, on the basis of any actual or expected health 2326  
condition of the employee or dependent. 2327

If, prior to November 24, 1995, a carrier excluded an 2328  
eligible employee or dependent, other than a late enrollee, on 2329  
the basis of an actual or expected health condition, the carrier 2330  
shall, upon the initial renewal of the coverage on or after that 2331  
date, extend coverage to the employee or dependent if all other 2332  
eligibility requirements are met. 2333

~~(D)~~ (C) No health benefit plan issued by a carrier shall 2334  
limit or exclude, by use of a rider or amendment applicable to a 2335  
specific individual, coverage by type of illness, treatment, 2336  
medical condition, or accident, ~~except for pre-existing~~ 2337  
~~conditions as permitted under division (A) of this section.~~ If a 2338  
health benefit plan that is delivered or issued for delivery 2339  
prior to April 14, 1993, contains such limitations or 2340  
exclusions, by use of a rider or amendment applicable to a 2341  
specific individual, the plan shall eliminate the use of such 2342  
riders or amendments within eighteen months after April 14, 2343  
1993. 2344

~~(E)~~ (D) (1) Except as provided in sections 3924.031 and 2345  
3924.032 of the Revised Code, and subject to such rules as may 2346  
be adopted by the superintendent of insurance in accordance with 2347  
Chapter 119. of the Revised Code, a carrier shall offer and make 2348  
available every health benefit plan that it is actively 2349  
marketing to every small employer that applies to the carrier 2350  
for such coverage. 2351

Division ~~(E)~~(D) (1) of this section does not apply to a 2352  
health benefit plan that a carrier makes available in the small 2353  
employer market only through one or more bona fide associations. 2354

Division ~~(E)~~(D) (1) of this section shall not be construed 2355  
to preclude a carrier from establishing employer contribution 2356  
rules or group participation rules for the offering of coverage 2357  
in connection with a group health benefit plan in the small 2358  
employer market, as allowed under the law of this state. As used 2359  
in division ~~(E)~~(D) (1) of this section, "employer contribution 2360  
rule" means a requirement relating to the minimum level or 2361  
amount of employer contribution toward the premium for 2362  
enrollment of employees and dependents and "group participation 2363  
rule" means a requirement relating to the minimum number of 2364  
employees or dependents that must be enrolled in relation to a 2365  
specified percentage or number of eligible individuals or 2366  
employees of an employer. 2367

(2) Each health benefit plan, at the time of initial group 2368  
enrollment, shall make coverage available to all the eligible 2369  
employees of a small employer without a service waiting period. 2370  
The decision of whether to impose a service waiting period shall 2371  
be made by the small employer. Such waiting periods shall not be 2372  
greater than ninety days. 2373

(3) Each health benefit plan shall provide for the special 2374  
enrollment periods described in section 2701(f) of the "Health 2375  
Insurance Portability and Accountability Act of 1996." 2376

(4) At least once in every twelve-month period, a carrier 2377  
shall provide to all late enrollees who are identified by the 2378  
small employer, the option to enroll in the health benefit plan. 2379  
The enrollment option shall be provided for a minimum period of 2380  
thirty consecutive days. All delays of coverage imposed under 2381

the health benefit plan, including any ~~pre-existing condition-~~ 2382  
~~exclusion period,~~ affiliation period, or service waiting period, 2383  
shall begin on the date the carrier receives notice of the late 2384  
enrollee's application or request for coverage, and shall run 2385  
concurrently with each other. 2386

~~(F)~~ (E) The benefit structure of any health benefit plan 2387  
may, at the time of coverage renewal, be changed by the carrier 2388  
to make it consistent with the benefit structure contained in 2389  
health benefit plans being marketed to new small employer 2390  
groups. If the health benefit plan is available in the small 2391  
employer market other than only through one or more bona fide 2392  
associations, the modification must be consistent with the law 2393  
of this state and effective on a uniform basis among small 2394  
employer group plans. 2395

~~(G)~~ (F) A carrier may obtain any facts and information 2396  
necessary to apply this section, or supply those facts and 2397  
information to any other third-party payer, without the consent 2398  
of the beneficiary. Each person claiming benefits under a health 2399  
benefit plan shall provide any facts and information necessary 2400  
to apply this section. 2401

For purposes of this section, "bona fide association" 2402  
means an association that has been actively in existence for at 2403  
least five years; has been formed and maintained in good faith 2404  
for purposes other than obtaining insurance; does not condition 2405  
membership in the association on any health status-related 2406  
factor, as defined in section 3924.031 of the Revised Code, 2407  
relating to an individual, including an employee or dependent; 2408  
makes health insurance coverage offered through the association 2409  
available to all members regardless of any health status-related 2410  
factor, as defined in section 3924.031 of the Revised Code, 2411

relating to such members or to individuals eligible for coverage 2412  
through a member; does not make health insurance coverage 2413  
offered through the association available other than in 2414  
connection with a member of the association; and meets any other 2415  
requirement imposed by the superintendent. To maintain its 2416  
status as a "bona fide association," each association shall 2417  
annually certify to the superintendent that it meets the 2418  
requirements of this paragraph. 2419

**Sec. 3924.033.** (A) Each carrier, in connection with the 2420  
offering of a health benefit plan to a small employer, shall 2421  
disclose to the employer, as part of its solicitation and sales 2422  
materials, the following information: 2423

(1) The provisions of the plan concerning the carrier's 2424  
right to change premium rates and the factors that may affect 2425  
changes in premium rates; 2426

(2) The provisions of the plan relating to renewability of 2427  
coverage; 2428

~~(3) The provisions of the plan relating to any pre-~~ 2429  
~~existing condition exclusion;~~ 2430

~~(4) The benefits and premiums available under all health~~ 2431  
~~benefit plans for which the employer is qualified.~~ 2432

(B) The information described in division (A) of this 2433  
section shall be provided in a manner determined to be 2434  
understandable by the average small employer, and in a manner 2435  
sufficient to reasonably inform a small employer regarding the 2436  
employer's rights and obligations under the health benefit plan. 2437

(C) Nothing in this section requires a carrier to disclose 2438  
any information that is by law proprietary and trade secret 2439  
information. 2440

**Sec. 3924.06.** (A) Compliance with the underwriting and 2441  
rating requirements contained in sections 3924.01 to ~~3924.14~~ 2442  
3924.06 of the Revised Code shall be demonstrated through 2443  
actuarial certification. Carriers offering health benefit plans 2444  
to small employers shall file annually with the superintendent 2445  
of insurance an actuarial certification stating that the 2446  
underwriting and rating methods of the carrier do all of the 2447  
following: 2448

(1) Comply with accepted actuarial practices; 2449

(2) Are uniformly applied to health benefit plans covering 2450  
small employers; 2451

(3) Comply with the applicable provisions of sections 2452  
3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. 2453

(B) If a carrier has established a separate class of 2454  
business for one or more small employer health care alliances in 2455  
accordance with section 1731.09 of the Revised Code, this 2456  
section shall apply in accordance with section 1731.09 of the 2457  
Revised Code. 2458

(C) Carriers offering health benefit plans to small 2459  
employers shall file premium rates with the superintendent in 2460  
accordance with section 3923.02 of the Revised Code with respect 2461  
to the carrier's sickness and accident insurance policies sold 2462  
to small employers and in accordance with section 1751.12 of the 2463  
Revised Code with respect to the carrier's health insuring 2464  
corporation policies sold to small employers. 2465

**Sec. 3924.51.** (A) As used in this section: 2466

(1) "Child" means, in connection with any adoption or 2467  
placement for adoption of the child, an individual who has not 2468  
attained age eighteen as of the date of the adoption or 2469

placement for adoption. 2470

(2) "Health insurer" has the same meaning as in section 2471  
3924.41 of the Revised Code. 2472

(3) "Placement for adoption" means the assumption and 2473  
retention by a person of a legal obligation for total or partial 2474  
support of a child in anticipation of the adoption of the child. 2475  
The child's placement with a person terminates upon the 2476  
termination of that legal obligation. 2477

(B) If an individual or group health plan of a health 2478  
insurer makes coverage available for dependent children of 2479  
participants or beneficiaries, the plan shall provide benefits 2480  
to dependent children placed with participants or beneficiaries 2481  
for adoption under the same terms and conditions as apply to the 2482  
natural, dependent children of the participants and 2483  
beneficiaries, irrespective of whether the adoption has become 2484  
final. 2485

~~(C) A health plan described in division (B) of this 2486  
section shall not restrict coverage under the plan of any 2487  
dependent child adopted by a participant or beneficiary, or 2488  
placed with a participant or beneficiary for adoption, solely on 2489  
the basis of a pre-existing condition of the child at the time 2490  
that the child would otherwise become eligible for coverage 2491  
under the plan, if the adoption or placement for adoption occurs 2492  
while the participant or beneficiary is eligible for coverage 2493  
under the plan. 2494~~

**Sec. 3924.73.** (A) As used in this section: 2495

(1) "Health care insurer" means any person legally engaged 2496  
in the business of providing sickness and accident insurance 2497  
contracts in this state, a health insuring corporation organized 2498

under Chapter 1751. of the Revised Code, or any legal entity 2499  
that is self-insured and provides health care benefits to its 2500  
employees or members. 2501

(2) "Small employer" has the same meaning as in section 2502  
3924.01 of the Revised Code. 2503

(B) (1) Subject to division (B) (2) of this section, nothing 2504  
in sections 3924.61 to 3924.74 of the Revised Code shall be 2505  
construed to limit the rights, privileges, or protections of 2506  
employees or small employers under sections 3924.01 to ~~3924.14~~ 2507  
3924.06 of the Revised Code. 2508

(2) If any account holder enrolls or applies to enroll in 2509  
a policy or contract offered by a health care insurer providing 2510  
sickness and accident coverage that is more comprehensive than, 2511  
and has a deductible amount that is less than, the coverage and 2512  
deductible amount of the policy under which the account holder 2513  
currently is enrolled, the health care insurer to which the 2514  
account holder applies may subject the account holder to the 2515  
same medical review, waiting periods, and underwriting 2516  
requirements to which the health care insurer generally subjects 2517  
other enrollees or applicants, unless the account holder enrolls 2518  
or applies to enroll during a designated period of open 2519  
enrollment. 2520

**Section 2.** That existing sections 1731.03, 1731.04, 2521  
1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 2522  
1751.18, 1751.58, 1751.69, 3922.01, 3923.122, 3923.57, 3923.571, 2523  
3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 3924.51, 2524  
and 3924.73 of the Revised Code are hereby repealed. 2525

**Section 3.** That sections 1751.15, 3923.58, 3923.581, 2526  
3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 2527

3924.111, 3924.12, 3924.13, and 3924.14 of the Revised Code are 2528  
hereby repealed. 2529

**Section 4.** The amendments to sections 1751.16, 1751.17, 2530  
and 3923.122 of the Revised Code in Section 1 of this act, which 2531  
were suspended by Section 3 of Sub. S.B. 9 of the 130th General 2532  
Assembly and which suspension was extended by Section 610.53 of 2533  
Am. Sub. H.B. 49 of the 132nd General Assembly, do not affect 2534  
the suspension of those sections. If sections 1751.16, 1751.17, 2535  
and 3923.122 of the Revised Code become operational, they will 2536  
be so in either their form as amended by this act or as they are 2537  
later amended. 2538

**Section 5.** This act shall apply to health benefit plans, 2539  
as defined in section 3922.01 of the Revised Code, delivered, 2540  
issued for delivery, modified, or renewed on or after the 2541  
effective date of this act. 2542

**Section 6.** The General Assembly, applying the principle 2543  
stated in division (B) of section 1.52 of the Revised Code that 2544  
amendments are to be harmonized if reasonably capable of 2545  
simultaneous operation, finds that the following sections, 2546  
presented in this act as composites of the sections as amended 2547  
by the acts indicated, are the resulting versions of the 2548  
sections in effect prior to the effective date of the sections 2549  
as presented in this act: 2550

Section 1739.05 of the Revised Code as amended by Sub. 2551  
H.B. 156, Sub. S.B. 259, and Sub. S.B. 265, all of the 132nd 2552  
General Assembly. 2553

Section 1751.12 of the Revised Code as amended by both Am. 2554  
Sub. H.B. 59 and Sub. H.B. 3 of the 130th General Assembly. 2555