#### As Introduced

## 134th General Assembly

# Regular Session

H. B. No. 125

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## Representatives Crossman, Lightbody

Cosponsors: Representatives West, Miller, J., Smith, M., Galonski, Brent, Miranda, Troy, Weinstein, Smith, K., Lepore-Hagan, Skindell, Howse, Robinson, Boggs, Liston, Sweeney, Sheehy, Sobecki, Russo, Hicks-Hudson, Miller, A., Kelly, Blackshear, Upchurch, Brown, Denson, Crawley, O'Brien, Jarrells, Leland, Ingram, Boyd, Sykes

## A BILL

То	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, 3901.381,	3
	3922.01, 3923.122, 3923.57, 3923.571, 3923.85,	4
	3924.01, 3924.02, 3924.03, 3924.033, 3924.06,	5
	3924.51, and 3924.73; to enact sections 3902.40,	6
	3902.41, 3902.42, 3902.43, and 3902.44; and to	7
	repeal sections 1751.15, 3923.58, 3923.581,	8
	3923.582, 3923.59, 3924.07, 3924.08, 3924.09,	9
	3924.10, 3924.11, 3924.111, 3924.12, 3924.13,	10
	and 3924.14 of the Revised Code regarding health	11
	insurance 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, 3901.381, 3922.01, 3923.122, 3923.57,	15
3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06,	16

3924.51, and 3924.73 be amended and sections 3902.40, 3902.41,	17
3902.42, 3902.43, and 3902.44 of the Revised Code be enacted to	18
read as 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

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
<pre>into the agreement;</pre>	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

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

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

(9) Premium rate structures, which may be uniform or make	190
provision for age-specific rates, differentials based on number	191
of participants of an enrolled small employer, products and plan	192
options selected, and other factors, rate adjustments based on	193
consumer price indices, utilization, or other relevant factors,	194
notification of rate adjustments, and arbitration;	195
(10) Any responsibilities of the alliance for billing,	196
collection, and transmittal of premiums;	197
(11) Inclusion under the alliance program of small	198
employers that are members of other organizations described in	199
division (A)(1) of section 1731.01 of the Revised Code that	200
contract with the alliance for this purpose, and conditions	201
pertaining to those small employer members and to their	202
employees and retirees, and dependents and family members of	203
those employees or retirees, as applicable under the alliance	204
program;	205
(12) The agreement of the insurer to offer and sell one or	206
more health benefit plans to small employer members of another	207
small employer health care alliance that contracts with the	208
alliance for this purpose;	209
(13) Use of the health benefit plan options of the insurer	210
in the alliance program and use of the names of the alliance and	211
the insurer;	212
(14) Indemnification from claims and liability by reason	213
of acts or omissions of others;	214
(15) Ownership, use, availability, and maintenance of	215
confidentiality of data and records relating to the alliance	216
program;	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	220
alliance and the insurer to better provide for the articulation,	221
promotion, financing, and operation of the alliance program or a	222
health benefit plan under the program in furtherance of the	223
public purposes stated in section 1731.02 of the Revised Code.	224
(C) Neither an alliance program nor an agreement between	225
an alliance and an insurer is itself a policy or contract of	226
insurance, or a certificate, indorsement, rider, or application	227
forming any part of a policy, contract, or certificate of	228
insurance. Chapters 3905., 3933., and 3959. of the Revised Code	229
do not apply to an alliance program or to an agreement between	230
an alliance and an insurer thereunder, as such, or to the	231
functions of the alliance under an alliance program.	232
Sec. 1731.05. If a qualified alliance, or an alliance	233
that, based upon evidence of interest satisfactory to the	234
superintendent of insurance, will be a qualified alliance within	235
a reasonable time, submits a request for a proposal on a health	236
benefit plan to at least three insurers and does not receive at	237
least one reasonably responsive proposal within ninety days from	238
the date the last such request is submitted, the superintendent,	239
at the request of such alliance, may require that insurers offer	240
proposals to such alliance for health benefit plans for the	241
small employers within such alliance. Such proposals shall	242
include such coverage and benefits for such premiums, as shall	243
take into account the functions provided by the alliance and the	244
economies of scale, and have other terms and provisions as are	245
approved by the superintendent, consistent with the purposes and	246
standards set forth in section 1731.02 of the Revised Code.—In—	247

making the determination as to which insurers shall be asked to

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

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 3924.14	283
3924.06 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 $3924.14$ $3924.06$ of the Revised Code.	300
(5) An insurer shall apply sections 3924.01 to 3924.14	301
3924.06 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, <del>3923.581, </del> 3923.602, 3923.63,	338
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.87, 3923.89,	339
3923.90, 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 3902.43 of the	363

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

certified by an independent member of the American academy of

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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

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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
(1) Physical therapy services;	473
(m) Chiropractic services;	474

(n) Any other category of services approved by the	475
superintendent of insurance.	476
(2) If a health insuring corporation offers prescription	477
drug services under this division, the coverage shall include	478
prescription drug services for the treatment of biologically	479
based mental illnesses on the same terms and conditions as other	480
physical diseases and disorders.	481
(C) "Specialty health care services" means one of the	482
supplemental health care services listed in division (B) of this	483
section, when provided by a health insuring corporation on an	484
outpatient-only basis and not in combination with other	485
supplemental health care services.	486
(D) "Biologically based mental illnesses" means	487
schizophrenia, schizoaffective disorder, major depressive	488
disorder, bipolar disorder, paranoia and other psychotic	489
disorders, obsessive-compulsive disorder, and panic disorder, as	490
these terms are defined in the most recent edition of the	491
diagnostic and statistical manual of mental disorders published	492
by the American psychiatric association.	493
(E) "Closed panel plan" means a health care plan that	494
requires enrollees to use participating providers.	495
(F) "Compensation" means remuneration for the provision of	496
health care services, determined on other than a fee-for-service	497
or discounted-fee-for-service basis.	498
(G) "Contractual periodic prepayment" means the formula	499
for determining the premium rate for all subscribers of a health	500
insuring corporation.	501
(H) "Corporation" means a corporation formed under Chapter	502
1701. or 1702. of the Revised Code or the similar laws of	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. or 1706. of	541
the 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

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

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 accessed 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 630 631 Chapter 1785. of the Revised Code, provided that nothing in this 632 chapter or other provisions of law shall be construed to 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. 1751.06. Upon obtaining a certificate of authority as	671
required under this chapter, a health insuring corporation may	672
do all of the following:	673
(A) Enroll individuals and their dependents in either of	674
the following circumstances:	675
(1) The individual resides or lives in the approved	676
service area.	677
(2) The individual's place of employment is located in the	678
approved service area.	679
(B) Contract with providers and health care facilities for	680

the health care services to which enrollees are entitled under	681
the terms of the health insuring corporation's health care	682
contracts;	683
(C) Contract with insurance companies authorized to do	684
business in this state for insurance, indemnity, or	685
reimbursement against the cost of providing emergency and	686
nonemergency health care services for enrollees, subject to the	687
provisions set forth in this chapter and the limitations set	688
forth in the Revised Code;	689
(D) Contract with any person pursuant to the requirements	690
of division (A)(18) of section 1751.03 of the Revised Code for	691
managerial or administrative services, or for data processing,	692
actuarial analysis, billing services, or any other services	693
authorized by the superintendent of insurance. However, a health	694
insuring corporation shall not enter into a contract for any of	695
the services listed in this division with an insurance company	696
that is not authorized to engage in the business of insurance in	697
this state.	698
(E) Accept from governmental agencies, private agencies,	699
corporations, associations, groups, individuals, or other	700
persons, payments covering all or part of the costs of planning,	701
development, construction, and the provision of health care	702
services;	703
(F) Purchase, lease, construct, renovate, operate, or	704
maintain health care facilities, and their ancillary equipment,	705
and any property necessary in the transaction of the business of	706
the health insuring corporation;	707
(G) In the employer group market, impose an affiliation	708
period of not more than sixty days, or for late enrollees an	709

affiliation period of not more than ninety days, which period	710
begins on the individual's date of enrollment and runs	711
concurrently with any waiting period imposed under the coverage.	712
For purposes of this division, "affiliation period" means a	713
period of time which, under the terms of the coverage offered,	714
must expire before the coverage becomes effective. No health	715
care services or benefits need to be provided during an	716
affiliation period, and no periodic prepayments can be charged	717
for any coverage during that period.	718
(H) If a health insuring corporation offers coverage in	719
the small employer group market through a network plan, limit or	720
deny the coverage in accordance with section 3924.031 of the	721
Revised Code;	722
(I) Refuse to issue coverage in the small employer group	723
market pursuant to section 3924.032 of the Revised Code;	724
(J) Establish employer contribution rules or group	725
participation rules for the offering of coverage in connection	726
with a group contract in the small employer group market, as	727
provided in division $\frac{\text{(E)}_{(D)}}{\text{(1)}}$ of section 3924.03 of the Revised	728
Code.	729
Nothing in this section shall be construed as prohibiting	730
a health insuring corporation without other commercial	731
enrollment from contracting solely with federal health care	732
programs regulated by federal regulatory bodies.	733
Nothing in this section shall be construed to limit the	734
authority of a health insuring corporation to perform those	735
functions not otherwise prohibited by law.	736
Sec. 1751.12. (A)(1) No contractual periodic prepayment	7.37

and no premium rate for nongroup and conversion policies for

health care services, or any amendment to them, may be used by	739
any health insuring corporation at any time until the	740
contractual periodic prepayment and premium rate, or amendment,	741
have been filed with the superintendent of insurance, and shall	742
not be effective until the expiration of sixty days after their	743
filing unless the superintendent sooner gives approval. The	744
filing shall be accompanied by an actuarial certification in the	745
form prescribed by the superintendent. The superintendent shall	746
disapprove the filing, if the superintendent determines within	747
the sixty-day period that the contractual periodic prepayment or	748
premium rate, or amendment, is not in accordance with sound	749
actuarial principles or is not reasonably related to the	750
applicable coverage and characteristics of the applicable class	751
of enrollees. The superintendent shall notify the health	752
insuring corporation of the disapproval, and it shall thereafter	753
be unlawful for the health insuring corporation to use the	754
contractual periodic prepayment or premium rate, or amendment.	755

- (2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.
- (3) At any time, the superintendent, upon at least thirty 767 days' written notice to a health insuring corporation, may 768 withdraw the approval given under division (A)(1) of this 769

section, deemed or actual, of any contractual periodic	770
prepayment or premium rate, or amendment, based on information	771
that either of the following applies:	772
(a) The contractual periodic prepayment or premium rate,	773
or amendment, is not in accordance with sound actuarial	774
principles.	775
(b) The contractual periodic prepayment or premium rate,	776
or amendment, is not reasonably related to the applicable	777
coverage and characteristics of the applicable class of	778
enrollees.	779
(4) Any disapproval under division (A)(1) of this section,	780
any rejection of a filing made under division (A)(2) of this	781
section, or any withdrawal of approval under division (A)(3) of	782
this section, shall be effected by a written notice, which shall	783
state the specific basis for the disapproval, rejection, or	784
withdrawal and shall be issued in accordance with Chapter 119.	785
of the Revised Code.	786
(B) Notwithstanding division (A) of this section, a health	787
insuring corporation may use a contractual periodic prepayment	788
or premium rate for policies used for the coverage of	789
beneficiaries enrolled in medicare pursuant to a medicare risk	790
contract or medicare cost contract, or for policies used for the	791
coverage of beneficiaries enrolled in the federal employees	792
health benefits program pursuant to 5 U.S.C.A. 8905, or for	793
policies used for the coverage of medicaid recipients, or for	794
policies used for the coverage of beneficiaries under any other	795
federal health care program regulated by a federal regulatory	796
body, or for policies used for the coverage of beneficiaries	797
under any contract covering officers or employees of the state	798

that has been entered into by the department of administrative

services, if both of the following apply:	800
(1) The contractual periodic prepayment or premium rate	801
has been approved by the United States department of health and	802
human services, the United States office of personnel	803
management, the department of medicaid, or the department of	804
administrative services.	805
(2) The contractual periodic prepayment or premium rate is	806
filed with the superintendent prior to use and is accompanied by	807
documentation of approval from the United States department of	808
health and human services, the United States office of personnel	809
management, the department of medicaid, or the department of	810
administrative services.	811
(C) The administrative expense portion of all contractual	812
periodic prepayment or premium rate filings submitted to the	813
superintendent for review must reflect the actual cost of	814
administering the product. The superintendent may require that	815
the administrative expense portion of the filings be itemized	816
and supported.	817
(D)(1) Copayments, cost sharing, and deductibles must be	818
reasonable and must not be a barrier to the necessary	819
utilization of services by enrollees.	820
(2) A health insuring corporation, in order to ensure that	821
copayments, cost sharing, and deductibles are reasonable and not	822
a barrier to the necessary utilization of basic health care	823
services by enrollees shall impose copayment charges, cost	824
sharing, and deductible charges that annually do not exceed	825
forty per cent of the total annual cost to the health insuring	826
corporation of providing all covered health care services when	827
applied to a standard population expected to be covered under	828

the filed product in question. The total annual cost of	829
providing a health care service is the cost to the health	830
insuring corporation of providing the health care service to its	831
enrollees as reduced by any applicable provider discount. This	832
requirement shall be demonstrated by an actuary who is a member	833
of the American academy of actuaries and qualified to provide	834
such certifications as described in the United States	835
qualification standards promulgated by the American academy of	836
actuaries pursuant to the code of professional conduct.	837
(3) For purposes of division (D) of this section, all of	838
the following apply:	839
(a) Copayments imposed by health insuring corporations in	840
connection with a high deductible health plan that is linked to	841
a health savings account are reasonable and are not a barrier to	842
the necessary utilization of services by enrollees.	843
(b) Division (D)(2) of this section does not apply to a	844
high deductible health plan that is linked to a health savings	845
account.	846
(c) Catastrophic-only plans, as <u>described in division (D)</u>	847
(2) of section 3902.43 of the Revised Code and defined under the	848
"Patient Protection and Affordable Care Act," 124 Stat. 119, 42	849
U.S.C. 18022 and any related regulations, are not subject to the	850
limits prescribed in division (D) of this section, provided that	851
such plans meet all applicable minimum federal requirements.	852
(E) A health insuring corporation shall not impose	853
lifetime maximums on basic health care services. However, a	854
health insuring corporation may establish a benefit limit for	855
inpatient hospital services that are provided pursuant to a	856

policy, contract, certificate, or agreement for supplemental

health care services.	858
(F) The superintendent may adopt rules allowing different	859
copayment, cost sharing, and deductible amounts for plans with a	860
medical savings account, health reimbursement arrangement,	861
flexible spending account, or similar account;	862
(G) A health insuring corporation may impose higher	863
copayment, cost sharing, and deductible charges under health	864
plans if requested by the group contract, policy, certificate,	865
or agreement holder, or an individual seeking coverage under an	866
individual health plan. This shall not be construed as requiring	867
the health insuring corporation to create customized health	868
plans for group contract holders or individuals.	869
(H) As used in this section, "health savings account" and	870
"high deductible health plan" have the same meanings as in the	871
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223,	872
as amended.	873
Sec. 1751.16. (A) Except as provided in division (F) of	874
this section, every group contract issued by a health insuring	875
corporation shall provide an option for conversion to an	876
individual contract issued on a direct-payment basis to any	877
subscriber covered by the group contract who terminates	878
employment or membership in the group, unless:	879
(1) Termination of the conversion option or contract is	880
based upon nonpayment of premium after reasonable notice in	881
writing has been given by the health insuring corporation to the	882
subscriber.	883
(2) The subscriber is, or is eligible to be, covered for	884
benefits at least comparable to the group contract under any of	885
the following:	886

(a) Medicare;	887
(b) Any act of congress or law under this or any other	888
state of the United States providing coverage at least	889
comparable to the benefits under division (A)(2)(a) of this	890
section;	891
(c) Any policy of insurance or health care plan providing	892
coverage at least comparable to the benefits under division (A)	893
(2) (a) of this section.	894
(B) (1) The direct payment contract offered by the health	895
insuring corporation pursuant to division (A) of this section	896
shall provide the following:	897
(a) In the case of an individual who is not a federally	898
eligible individual, benefits comparable to benefits in any of	899
the individual contracts then being issued to individual	900
	0.01
subscribers by the health insuring corporation;	901
(b) In the case of a federally eligible individual, a	901
(b) In the case of a federally eligible individual, a	902
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the	902 903
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and	902 903 904
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.	902 903 904 905
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B)(1)(b) of this section, the	902 903 904 905 906
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is	902 903 904 905 906 907
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit	902 903 904 905 906 907 908
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic	902 903 904 905 906 907 908 909
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed the amounts	902 903 904 905 906 907 908 909
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed the amounts specified below:	902 903 904 905 906 907 908 909 910 911
(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services.  For purposes of division (B) (1) (b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed the amounts specified below:  (i) For calendar years 2010 and 2011, an amount that is	902 903 904 905 906 907 908 909 910 911

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(11) For calendar year 2012 and every calendar year	916
thereafter, an amount that is one and one-half times the base	917
rate charged any other individual of a group to which the health-	918
insuring corporation is currently accepting new business and for-	919
which similar copayments and deductibles are applied, unless the	920
superintendent of insurance determines that the amendments by	921
this act to sections 3923.58 and 3923.581 of the Revised Code,	922
have resulted in the market wide average medical loss ratio for-	923
coverage sold to individual insureds and nonemployer group-	924
insureds in this state, including open enrollment insureds, to	925
increase by more than five and one quarter percentage points	926
during calendar year 2010. If the superintendent makes that	927
determination, the premium limit established by division (B)(1)	928
(b) (i) of this section shall remain in effect.	929
(2) The direct payment contract offered pursuant to	930
division (A) of this section may include a coordination of	931
benefits provision as approved by the superintendent.	932
(3) For purposes of division (B) of this section:	933
(a) "Federally eligible individual" means an eligible-	934
individual as defined in 45 C.F.R. 148.103.	935
(b) "Base rate" means, as to any health benefit plan that	936
is issued by a health insuring corporation, the lowest premium	937
rate for new or existing business prescribed by the health	938
insuring corporation for the same or similar coverage under a	939
plan or arrangement covering any individual in a group with-	940
similar case characteristics.	941
(C) The option for conversion shall be available:	942
(1) Upon the death of the subscriber, to the surviving	943

spouse with respect to such of the spouse and dependents as are

then covered by the group contract;	945
(2) To a child solely with respect to the child upon the	946
child's attaining the limiting age of coverage under the group	947
contract while covered as a dependent under the contract;	948
(3) Upon the divorce, dissolution, or annulment of the	949
marriage of the subscriber, to the divorced spouse, or, in the	950
event of annulment, to the former spouse of the subscriber.	951
(D) No health insuring corporation shall use age or health	952
status as the basis for refusing to renew a converted contract.	953
(E) Written notice of the conversion option provided by	954
this section shall be given to the subscriber by the health	955
insuring corporation by mail. The notice shall be sent to the	956
subscriber's address in the records of the employer upon receipt	957
of notice from the employer of the event giving rise to the	958
conversion option. If the subscriber has not received notice of	959
the conversion privilege at least fifteen days prior to the	960
expiration of the thirty-day conversion period, then the	961
subscriber shall have an additional period within which to	962
exercise the privilege. This additional period shall expire	963
fifteen days after the subscriber receives notice, but in no	964
event shall the period extend beyond sixty days after the	965
expiration of the thirty-day conversion period.	966
(F) This section does not apply to any group contract	967
offering only supplemental health care services or specialty	968
health care services.	969
Sec. 1751.18. (A)(1) No health insuring corporation shall	970
cancel or fail to renew the coverage of a subscriber or enrollee	971
because of any health status-related factor in relation to the	972
subscriber or enrollee, the subscriber's or enrollee's	973

requirements for health care services, or for any other reason 974 designated under rules adopted by the superintendent of 975 insurance. 976

- (2) Unless otherwise required by state or federal law, no 977 health insuring corporation, or health care facility or provider 978 through which the health insuring corporation has made 979 arrangements to provide health care services, shall discriminate 980 against any individual with regard to enrollment, disenrollment, 981 or the quality of health care services rendered, on the basis of 982 983 the individual's race, color, sex, age, religion, military status as defined in section 4112.01 of the Revised Code, or 984 status as a recipient of medicare or medicaid, or any health 985 status-related factor in relation to the individual. However, a 986 health insuring corporation shall not be required to accept a 987 recipient of medicare or medical assistance, if an agreement has 988 not been reached on appropriate payment mechanisms between the 989 health insuring corporation and the governmental agency 990 991 administering these programs. Further, except for open-992 enrollment coverage under sections 3923.58 and 3923.581 of the Revised Code and except as provided in section 1751.65 of the 993 994 Revised Code, a health insuring corporation may reject an-995 applicant for nongroup enrollment on the basis of any health status-related factor in relation to the applicant. 996
- (B) A health insuring corporation may cancel or decide not

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  to renew the coverage of an enrollee if the enrollee has

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  performed an act or practice that constitutes fraud or

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  intentional misrepresentation of material fact under the terms

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  of the coverage and if the cancellation or nonrenewal is not

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  based, either directly or indirectly, on any health status
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  related factor in relation to the enrollee.

(C) An enrollee may appeal any action or decision of a	1004
health insuring corporation taken pursuant to section 2742(b) to	1005
(e) of the "Health Insurance Portability and Accountability Act	1006
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A.	1007
300gg-42, as amended. To appeal, the enrollee may submit a	1008
written complaint to the health insuring corporation pursuant to	1009
section 1751.19 of the Revised Code. The enrollee may, within	1010
thirty days after receiving a written response from the health	1011
insuring corporation, appeal the health insuring corporation's	1012
action or decision to the superintendent.	1013
(D) As used in this section, "health status-related	1014
factor" means any of the following:	1015
(1) Health status;	1016
(2) Medical condition, including both physical and mental	1017
illnesses;	1018
(3) Claims experience;	1019
(4) Receipt of health care;	1020
(5) Medical history;	1021
(6) Genetic information;	1022
(7) Evidence of insurability, including conditions arising	1023
out of acts of domestic violence;	1024
(8) Disability.	1025
Sec. 1751.58. Except as otherwise provided in section 2721	1026
of the "Health Insurance Portability and Accountability Act of	1027
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-	1028
21, as amended, the following conditions apply to all group	1029
health insuring corporation contracts that are sold in	1030

connection with an employment-related group health care plan and	1031
that are not subject to section 3924.03 of the Revised Code:	1032
(A)(1) Except as provided in section 2712(b) to (e) of the	1033
"Health Insurance Portability and Accountability Act of 1996,"	1034
if a health insuring corporation offers coverage in the small or	1035
large group market in connection with a group contract, the	1036
corporation shall renew or continue in force such coverage at	1037
the option of the contract holder.	1038
(2) A health insuring corporation may cancel or decide not	1039
to renew the coverage of any eligible employee or of a dependent	1040
of an eligible employee under the group contract in accordance	1041
with division (B) of section 1751.18 of the Revised Code.	1042
(B) Such group contracts are subject to $\frac{\text{division}}{\text{division}}$	1043
section 3924.03 and sections 3924.033 and 3924.27 of the Revised	1044
Code.	1045
(C) Such group contracts shall provide for the special	1046
enrollment periods described in section 2701(f) of the "Health	1047
Insurance Portability and Accountability Act of 1996."	1048
(D) At least once in every twelve-month period, a health	1049
insuring corporation shall provide to all late enrollees, as	1050
defined in section 3924.01 of the Revised Code, who are	1051
identified by the contract holder, the option to enroll in the	1052
group contract. The enrollment option shall be provided for a	1053
minimum period of thirty consecutive days. All delays of	1054
coverage imposed under the group contract, including any	1055
affiliation period, shall begin on the date the health insuring	1056
corporation receives notice of the late enrollee's application	1057
or request for coverage, and shall run concurrently with each	1058
other.	1059

Sec. 1751.69. (A) As used in this section, "cost sharing"	1060
means the cost to an individual insured under an individual or	1061
group health insuring corporation policy, contract, or agreement	1062
according to any coverage limit, copayment, coinsurance,	1063
deductible, or other out-of-pocket expense requirements imposed	1064
by the policy, contract, or agreement.	1065
(B) Notwithstanding section 3901.71 of the Revised Code	1066
and subject to division (D) of this section, no individual or	1067
group health insuring corporation policy, contract, or agreement	1068
providing basic health care services or prescription drug	1069
services that is delivered, issued for delivery, or renewed in	1070
this state, if the policy, contract, or agreement provides	1071
coverage for cancer chemotherapy treatment, shall fail to comply	1072
with either of the following:	1073
(1) The policy, contract, or agreement shall not provide	1074
coverage or impose cost sharing for a prescribed, orally	1075
administered cancer medication on a less favorable basis than	1076
the coverage it provides or cost sharing it imposes for	1077
intraveneously administered or injected cancer medications.	1078
(2) The policy, contract, or agreement shall not comply	1079
with division (B)(1) of this section by imposing an increase in	1080
cost sharing solely for orally administered, intravenously	1081
administered, or injected cancer medications.	1082
(C) Notwithstanding any provision of this section to the	1083
contrary, an individual or group health insuring corporation	1084
policy, contract, or agreement shall be deemed to be in	1085
compliance with this section if the cost sharing imposed under	1086
such a policy, contract, or agreement for orally administered	1087

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cancer treatments does not exceed one hundred dollars per

prescription fill. The cost <u>-</u>sharing limit of one hundred

dollars per prescription fill shall apply to a high deductible	1090
plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as	1091
described in division (D)(2) of section 3902.43 of the Revised	1092
<pre>Code and defined in 42 U.S.C. 18022, only after the deductible</pre>	1093
has been met.	1094
(D) The prohibitions in division (B) of this section do	1095
not preclude an individual or group health insuring corporation	1096
policy, contract, or agreement from requiring an enrollee to	1097
obtain prior authorization before orally administered cancer	1098
medication is dispensed to the enrollee.	1099
(E) A health insuring corporation that offers coverage for	1100
basic health care services is not required to comply with	1101
division (B) of this section if all of the following apply:	1102
(1) The health insuring corporation submits documentation	1103
certified by an independent member of the American academy of	1104
actuaries to the superintendent of insurance showing that	1105
compliance with division (B)(1) of this section for a period of	1106
at least six months independently caused the health insuring	1107
corporation's costs for claims and administrative expenses for	1108
the coverage of basic health care services to increase by more	1109
than one per cent per year.	1110
(2) The health insuring corporation submits a signed	1111
letter from an independent member of the American academy of	1112
actuaries to the superintendent of insurance opining that the	1113
increase in costs described in division (E)(1) of this section	1114
could reasonably justify an increase of more than one per cent	1115
in the annual premiums or rates charged by the health insuring	1116
corporation for the coverage of basic health care services.	1117

(3) (a) The superintendent of insurance makes the following

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determinations from the documentation and opinion submitted	1119
pursuant to divisions (E)(1) and (2) of this section:	1120
(i) Compliance with division (B)(1) of this section for a	1121
period of at least six months independently caused the health	1122
insuring corporation's costs for claims and administrative	1123
expenses for the coverage of basic health care services to	1124
increase more than one per cent per year.	1125
(ii) The increase in costs reasonably justifies an	1126
increase of more than one per cent in the annual premiums or	1127
rates charged by the health insuring corporation for the	1128
coverage of basic health care services.	1129
(b) Any determination made by the superintendent under	1130
division (E)(3) of this section is subject to Chapter 119. of	1131
the Revised Code.	1132
Sec. 3901.381. (A) Except as provided in sections	1133
Sec. 3901.381. (A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code,	1133 1134
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code,	1134
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health	1134 1135
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in	1134 1135 1136
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.	1134 1135 1136 1137
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section	1134 1135 1136 1137
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section applies, when a third-party payer receives from a provider or	1134 1135 1136 1137 1138 1139
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in	1134 1135 1136 1137 1138 1139 1140
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section	1134 1135 1136 1137 1138 1139 1140 1141
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or	1134 1135 1136 1137 1138 1139 1140 1141 1142
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the	1134 1135 1136 1137 1138 1139 1140 1141 1142 1143
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.  (B) (1) Unless division (B) (2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party	1134 1135 1136 1137 1138 1139 1140 1141 1142 1143

(2)(a) Unless division (B)(3) of this section applies,	1148
when a provider or beneficiary has used the standard claim form,	1149
but the third-party payer determines that reasonable supporting	1150
documentation is needed to establish the third-party payer's	1151
responsibility to make payment, the third-party payer shall pay	1152
or deny the claim not later than forty-five days after receipt	1153
of the claim. Supporting documentation includes the verification	1154
of employer and beneficiary coverage under a benefits contract,	1155
confirmation of premium payment, medical information regarding	1156
the beneficiary and the services provided, information on the	1157
responsibility of another third-party payer to make payment or	1158
confirmation of the amount of payment by another third-party	1159
payer, and information that is needed to correct material	1160
deficiencies in the claim related to a diagnosis or treatment or	1161
the provider's identification.	1162

Not later than thirty days after receipt of the claim, the 1163 third-party payer shall notify all relevant external sources 1164 that the supporting documentation is needed. All such notices 1165 shall state, with specificity, the supporting documentation 1166 needed. If the notice was not provided in writing, the provider, 1167 beneficiary, or third-party payer may request the third-party 1168 payer to provide the notice in writing, and the third-party 1169 payer shall then provide the notice in writing. If any of the 1170 supporting documentation is under the control of the 1171 beneficiary, the beneficiary shall provide the supporting 1172 documentation to the third-party payer. 1173

The number of days that elapse between the third-party

payer's last request for supporting documentation within the

thirty-day period and the third-party payer's receipt of all of

the supporting documentation that was requested shall not be

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counted for purposes of determining the third-party payer's

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compliance with the time period of not more than forty-five days	1179
for payment or denial of a claim. Except as provided in division	1180
(B)(2)(b) of this section, if If the third-party payer requests	1181
additional supporting documentation after receiving the	1182
initially requested documentation, the number of days that	1183
elapse between making the request and receiving the additional	1184
supporting documentation shall be counted for purposes of	1185
determining the third-party payer's compliance with the time	1186
period of not more than forty-five days.	1187
(b) If a third-party payer determines, after receiving	1188
initially requested documentation, that it needs additional	1189
supporting documentation pertaining to a beneficiary's	1190
preexisting condition, which condition was unknown to the third-	1191
party payer and about which it was reasonable for the third-	1192
party payer to have no knowledge at the time of its initial	1193
request for documentation, and the third party payer	1194
subsequently requests this additional supporting documentation,	1195
the number of days that elapse between making the request and	1196
receiving the additional supporting documentation shall not be	1197
counted for purposes of determining the third-party payer's	1198
compliance with the time period of not more than forty-five	1199
<del>days.</del>	1200
(c) When a third-party payer denies a claim, the third-	1201
party payer shall notify the provider and the beneficiary. The	1202
notice shall state, with specificity, why the third-party payer	1203
denied the claim.	1204
(d) (c) If a third-party payer determines that supporting	1205
documentation related to medical information is routinely	1206
necessary to process a claim for payment of a particular health	1207
care service, the third-party payer shall establish a	1208

description of the	supporting documentation that is routinely	1209
necessary and make	the description available to providers in a	1210
readily accessible	format.	1211

Third-party payers and providers shall, in connection with 1212 a claim, use the most current CPT code in effect, as published 1213 by the American medical association, the most current ICD-10 1214 code in effect, as published by the United States department of 1215 health and human services, the most current CDT code in effect, 1216 as published by the American dental association, or the most 1217 current HCPCS code in effect, as published by the United States 1218 centers for medicare and medicaid services. 1219

(3) When a provider or beneficiary submits a claim by 1220 using the standard claim form prescribed in the superintendent's 1221 rules, but the information provided in the claim is materially 1222 deficient, the third-party payer shall notify the provider or 1223 beneficiary not later than fifteen days after receipt of the 1224 claim. The notice shall state, with specificity, the information 1225 needed to correct all material deficiencies. Once the material 1226 deficiencies are corrected, the third-party payer shall proceed 1227 in accordance with division (B)(1) or (2) of this section. 1228

It is not a violation of the notification time period of 1229 not more than fifteen days if a third-party payer fails to 1230 notify a provider or beneficiary of material deficiencies in the 1231 claim related to a diagnosis or treatment or the provider's 1232 identification. A third-party payer may request the information 1233 necessary to correct these deficiencies after the end of the 1234 notification time period. Requests for such information shall be 1235 made as requests for supporting documentation under division (B) 1236 (2) of this section, and payment or denial of the claim is 1237 subject to the time periods specified in that division. 1238

(C) For purposes of this section, if a dispute exists	1239
between a provider and a third-party payer as to the day a claim	1240
form was received by the third-party payer, both of the	1241
following apply:	1242
(1) If the provider or a person acting on behalf of the	1243
provider submits a claim directly to a third-party payer by mail	1244
and retains a record of the day the claim was mailed, there	1245
exists a rebuttable presumption that the claim was received by	1246
the third-party payer on the fifth business day after the day	1247
the claim was mailed, unless it can be proven otherwise.	1248
(2) If the provider or a person acting on behalf of the	1249
provider submits a claim directly to a third-party payer	1250
electronically, there exists a rebuttable presumption that the	1251
claim was received by the third-party payer twenty-four hours	1252
after the claim was submitted, unless it can be proven	1253
otherwise.	1254
(D) Nothing in this section requires a third-party payer	1255
to provide more than one notice to an employer whose premium for	1256
coverage of employees under a benefits contract has not been	1257
received by the third-party payer.	1258
(E) Compliance with the provisions of division (B)(3) of	1259
this section shall be determined separately from compliance with	1260
the provisions of divisions (B)(1) and (2) of this section.	1261
(F) A third-party payer shall transmit electronically any	1262
payment with respect to claims that the third-party payer	1263
receives electronically and pays to a contracted provider under	1264
this section and under sections 3901.383, 3901.384, and 3901.386	1265
of the Revised Code. A provider shall not refuse to accept a	1266
payment made under this section or sections 3901.383, 3901.384,	1267

and 3901.386 of the Revised Code on the basis that the payment	1268
was transmitted electronically.	1269
Sec. 3902.40. As used in sections 3902.40 to 3902.44 of	1270
the Revised Code:	1271
(A) "Cost sharing" means the cost to a covered person_	1272
	1272
under a health benefit plan according to any coverage limit,	
copayment, coinsurance, deductible, or other out-of-pocket	1274
<pre>expense requirement.</pre>	1275
(B) "Covered person," "health care provider" or	1276
"provider," "health care services," and "health plan issuer"	1277
have the same meanings as in section 3922.01 of the Revised	1278
Code.	1279
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(C) "Health benefit plan" has the same meaning as in	1280
section 3922.01 of the Revised Code, but does not include a	1281
limited benefit plan.	1282
(E) "Preexisting condition exclusion" means, with respect	1283
to a health benefit plan, a limitation or exclusion of benefits	1284
relating to a condition based on the fact that the condition was	1285
present before the date of enrollment in the plan, whether or	1286
not any medical advice, diagnosis, care, or treatment was	1287
recommended or received before such date. "Condition" does not	1288
include genetic information in the absence of a diagnosis of the	1289
condition related to such information.	1290
Sec. 3902.41. (A) With respect to the premium rate charged_	1291
by a health plan issuer for a health benefit plan offered in the	1292
individual or small group market, all of the following apply:	1293
(1) The premium rate shall vary with respect to the health	1294
benefit plan involved only by the following:	1295

(a) Whether the health benefit plan covers an individual	1296
or family;	1297
(b) Rating area, as established in accordance with	1298
division (C) (1) of this section;	1299
(c) Age, except that such rate shall not vary by more than	1300
three to one for adults;	1301
(d) Tobacco use, except that such rate shall not vary by	1302
more than one and one-half to one.	1303
(2) The premium rate shall not vary with respect to the	1304
health benefit plan involved by any other factor not described	1305
in division (A) of this section.	1306
(B) With respect to family coverage under a health benefit	1307
plan, the rating variations permitted under divisions (A)(1)(c)	1308
and (d) of this section shall be applied based on the portion of	1309
the premium that is attributable to each family member covered	1310
under the health benefit plan.	1311
(C) The superintendent of insurance shall adopt rules to	1312
do the following:	1313
(1) Establish one or more rating areas within the state;	1314
(2) Define the permissible age bands for rating purposes	1315
under division (A)(1)(c) of this section.	1316
(D) A health plan issuer shall not establish lifetime or	1317
annual limits on the dollar value of benefits described in	1318
section 3902.43 of the Revised Code for any covered person.	1319
Sec. 3902.42. (A) Every individual health benefit plan	1320
shall accept every individual in this state who applies for	1321
coverage and every group health benefit plan shall accept every	1322

<pre>employer in this state that applies for coverage, regardless of</pre>	1323
whether any individual or employee has a preexisting condition.	1324
A health benefit plan may restrict enrollment in coverage to	1325
open or special enrollment periods under division (C) of this	1326
section.	1327
(B) A health plan issuer shall not impose any preexisting	1328
condition exclusion on any person.	1329
(C) (1) The superintendent of insurance shall adopt rules	1330
to ensure that each individual health benefit plan has open	1331
<pre>enrollment during a statewide open enrollment period to allow</pre>	1332
individuals, including individuals who are not covered persons,	1333
to enroll in the health benefit plan.	1334
(2) A health plan issuer shall provide special enrollment	1335
periods for individuals who lose coverage as a result of a	1336
qualifying event under 26 U.S.C. 9801(f) or 29 U.S.C. 1163.	1337
Sec. 3902.43. (A) For purposes of this section, "essential	1338
health benefits package" means, with respect to a health benefit	1339
plan, coverage that does all of the following:	1340
(1) Provides for the essential health benefits defined by	1341
the superintendent of insurance under division (B) of this	1342
section;	1343
(2) Limits cost sharing for such coverage in accordance	1344
with division (C) of this section;	1345
(3) Provides the level of coverage described in division	1346
(D) of this section.	1347
(B) (1) Subject to division (B) (2) of this section, the	1348
superintendent shall define the essential health benefits,	1349
except that such benefits shall include at least the following	1350

general categories and the items and services covered within the	1351
categories:	1352
(a) Ambulatory patient services;	1353
(b) Emergency services;	1354
(c) Hospitalization;	1355
(d) Maternity and newborn care;	1356
(e) Mental health and substance use disorder services,	1357
including behavioral health treatment;	1358
(f) Prescription drugs;	1359
(g) Rehabilitative and habilitative services and devices;	1360
(h) Laboratory services;	1361
(i) Preventive and wellness services and chronic disease	1362
management;	1363
(j) Pediatric services, including oral and vision care.	1364
(2) (a) The superintendent shall ensure that the scope of	1365
the essential health benefits under division (B)(1) of this	1366
section is equal to the scope of benefits provided under a	1367
typical employer plan, as determined by the superintendent. To	1368
inform this determination, the superintendent shall conduct a	1369
survey of employer-sponsored coverage to determine the benefits	1370
typically covered by employers, including multi-employer plans.	1371
(b) In defining the essential health benefits described in	1372
division (B)(1) of this section, and in revising the benefits	1373
under division (B)(3)(q) of this section, the superintendent	1374
shall submit a report to the general assembly containing a	1375
certification that such essential health benefits meet the	1376
requirements described in division (B)(2)(a) of this section.	1377

(3) In defining the essential health benefits under	1378
division (B)(1) of this section, the superintendent shall do all	1379
of the following:	1380
(a) Ensure that such essential health benefits reflect an	1381
appropriate balance among the categories described in division	1382
(B) (1) of this section, so that benefits are not unduly weighted	1383
toward any category;	1384
(b) Not make coverage decisions, determine reimbursement	1385
rates, establish incentive programs, or design benefits in ways	1386
that discriminate against individuals because of their age,	1387
disability, or expected length of life;	1388
(c) Take into account the health care needs of diverse	1389
segments of the population, including women, children, persons	1390
with disabilities, and other groups;	1391
(d) Ensure that benefits established as essential health	1392
benefits not be subject to denial to individuals against their	1393
wishes on the basis of the individuals' age or expected length	1394
of life or of the individuals' present or predicted disability,	1395
degree of medical dependency, or quality of life;	1396
(e) Provide that a qualified health benefit plan shall not	1397
be treated as providing coverage for the essential health	1398
benefits described in division (B)(1) of this section unless the	1399
<pre>plan does both of the following:</pre>	1400
(i) Provides that coverage for emergency services, as	1401
defined in section 3923.65 of the Revised Code, will be provided	1402
without imposing any requirement under the plan for prior	1403
authorization of services or any limitation on coverage where	1404
the provider of services does not have a contractual	1405
relationship with the plan for the providing of services that is	1406

more restrictive than the requirements or limitations that apply	1407
to emergency services received from providers who do have such a	1408
contractual relationship with the plan;	1409
(ii) Provides that if emergency services are provided out-	1410
of-network, the cost-sharing requirement is the same requirement	1411
that would apply if such services were provided in-network.	1412
(f) Periodically review the essential health benefits	1413
under division (B)(1) of this section and provide a report to	1414
the general assembly and the public that contains all of the	1415
<pre>following:</pre>	1416
(i) An assessment of whether covered persons are facing	1417
any difficulty accessing needed services for reasons of coverage	1418
or cost;	1419
(ii) An assessment of whether the essential health	1420
benefits need to be modified or updated to account for changes	1421
in medical evidence or scientific advancement;	1422
(iii) Information on how the essential health benefits	1423
will be modified to address any such gaps in access or changes	1424
in the evidence base;	1425
(iv) An assessment of the potential of additional or	1426
expanded benefits to increase costs and the interactions between	1427
the addition or expansion of benefits and reductions in existing	1428
benefits to meet the requirements of division (B)(2)(a) of this	1429
section.	1430
(g) Periodically update the essential health benefits	1431
under division (B)(1) of this section to address any gaps in	1432
access to coverage or changes in the evidence base the	1433
superintendent identifies in the review conducted under division	1434
(B)(3)(f) of this section	1435

(4) Nothing in this section shall be construed to prohibit	1436
a health benefit plan from providing benefits in excess of the	1437
essential health benefits described in this section.	1438
(5) A health benefit plan shall not offer coverage for an	1439
essential health benefit identified in division (B)(1) of this	1440
section unless it offers coverage for all listed essential	1441
health benefits identified in that division.	1442
(C) (1) A health plan issuer shall not require cost sharing	1443
in an amount greater than eight thousand one hundred fifty	1444
dollars for self-only coverage and sixteen thousand three	1445
hundred dollars for other than self-only coverage for plan years	1446
a health benefit plan from providing benefits in excess of the essential health benefits described in this section.  (5) A health benefit plan shall not offer coverage for an essential health benefit identified in division (B)(1) of this section unless it offers coverage for all listed essential health benefits identified in that division.  (C)(1) A health plan issuer shall not require cost sharing in an amount greater than eight thousand one hundred fifty dollars for self-only coverage and sixteen thousand three hundred dollars for other than self-only coverage for plan years beginning in 2021.  (2) For plan years beginning in a calendar year after 2021, the cost-sharing limit shall be as follows:  (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;  (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.  (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,	1447
(2) For plan years beginning in a calendar year after	1448
2021, the cost-sharing limit shall be as follows:	1449
(a) In the case of self-only coverage, be equal to the	1450
dollar amount in division (C)(1) of this section, increased by	1451
the product of that amount and the premium adjustment percentage	1452
under division (C)(3) of this section for the calendar year;	1453
(b) In the case of other than self-only coverage, twice	1454
the amount in effect under division (C)(2)(a) of this section.	1455
If the amount of any increase under division (C)(2)(a) of this	1456
section is not a multiple of fifty dollars, such increase shall	1457
be rounded to the next lowest multiple of fifty dollars.	1458
(3) The premium adjustment percentage for any calendar	1459
year shall be the percentage by which the average per capita	1460
premium for health benefit plans in this state for the preceding	1461
calendar year, as estimated by the superintendent not later than	1462
the first day of October of such preceding calendar year,	1463
exceeds such average per capita premium for 2019, as determined	1464

by the superintendent.	1465
(D)(1)(a) Except as provided in division (D)(2) of this	1466
section, a health benefit plan shall provide a level of coverage	1467
that is designed to provide benefits that are actuarially	1468
equivalent to at least sixty per cent of the full actuarial	1469
value of the benefits provided under the plan.	1470
(b) Under rules issued by the superintendent, the level of	1471
coverage of a plan shall be determined on the basis that the	1472
essential health benefits described in division (B)(1) of this	1473
section shall be provided to a standard population, without	1474
regard to the population the plan may actually provide benefits	1475
to.	1476
(2) A health benefit plan that does not provide the level	1477
of coverage described in division (D)(1) of this section shall	1478
be considered as meeting the requirements of that division with	1479
respect to any plan year if both of the following apply:	1480
(a) An individual is only eligible to enroll in the health	1481
benefit plan if the individual meets either of the following	1482
<pre>conditions:</pre>	1483
(i) The individual has not attained the age of thirty	1484
before the beginning of the plan year.	1485
(ii) The individual meets a hardship exemption as	1486
determined by the superintendent.	1487
(b) The health benefit plan provides both of the	1488
<pre>following:</pre>	1489
(i) Except as provided in division (D)(2)(b)(ii) of this	1490
section, the essential health benefits listed in division (B)(1)	1491
of this section, except that the health benefit plan provides no	1492

benefits for any plan year until the individual has incurred	1493
cost-sharing expenses in an amount equal to the annual	1494
limitation in effect under division (C) of this section for the	1495
plan year except as provided for in section 3902.44 of the	1496
Revised Code;	1497
(ii) Coverage for at least three primary care visits.	1498
(3) If a health plan issuer offers a health benefit plan	1499
described in division (D)(2) of this section, the issuer shall	1500
only offer the plan in the individual market.	1501
(E) The requirements of this section do not apply to	1502
health benefit plans offered in the large group market.	1503
(F) Nothing in this section is subject to the requirements	1504
of section 3901.71 of the Revised Code.	1505
Sec. 3902.44. (A) A health benefit plan shall provide	1506
coverage for and shall not impose any cost-sharing requirements	1507
<pre>for the following:</pre>	1508
(1) Evidence-based items or services that have in effect a	1509
rating of "A" or "B" in the current recommendations of the	1510
United States preventive services task force;	1511
(2) Immunizations that have in effect a recommendation	1512
from the advisory committee on immunization practices of the	1513
United States centers for disease control and prevention with	1514
respect to the individual involved;	1515
(3) With respect to infants, children, and adolescents,	1516
evidence-informed preventive care and screenings provided for in	1517
the comprehensive guidelines supported by the United States	1518
health resources and services administration;	1519
(4) With respect to women, such additional preventive care	1520

and screenings not described in division (A)(1) of this section	1521
as provided for in comprehensive guidelines supported by the	1522
United States health resources and services administration.	1523
(B) The superintendent shall adopt rules to implement	1524
sections 3902.40 to 3902.44 of the Revised Code.	1525
Sec. 3922.01. As used in this chapter:	1526
(A) "Adverse benefit determination" means a decision by a	1527
health plan issuer:	1528
(1) To deny, reduce, or terminate a requested health care	1529
service or payment in whole or in part, including all of the	1530
following:	1531
(a) A determination that the health care service does not	1532
meet the health plan issuer's requirements for medical	1533
necessity, appropriateness, health care setting, level of care,	1534
or effectiveness, including experimental or investigational	1535
treatments;	1536
(b) A determination of an individual's eligibility for	1537
individual health insurance coverage, including coverage offered	1538
to individuals through a nonemployer group, to participate in a	1539
plan or health insurance coverage;	1540
(c) A determination that a health care service is not a	1541
covered benefit;	1542
(d) The imposition of an exclusion, including exclusions	1543
for pre-existing conditions, source of injury, network, or any	1544
other limitation on benefits that would otherwise be covered.	1545
(2) Not to issue individual health insurance coverage to	1546
an applicant, including coverage offered to individuals through	1547
a nonemployer group;	1548

(B) "Ambulatory review" has the same meaning as in section 15	50
1751.77 of the Revised Code.	51
(C) "Authorized representative" means an individual who 15	52
represents a covered person in an internal appeal or external 15	53
review process of an adverse benefit determination who is any of 15	54
the following:	55
(1) A person to whom a covered individual has given 15	556
express, written consent to represent that individual in an 15	57
internal appeals process or external review process of an 15	58
adverse benefit determination; 15	59
(2) A person authorized by law to provide substituted 15	60
consent for a covered individual; 15	61
(3) A family member or a treating health care	62
professional, but only when the covered person is unable to 15	63
provide consent. 15	64
(D) "Best evidence" means evidence based on all of the 15	65
following sources, listed according to priority, as they are 15	66
available: 15	67
(1) Randomized clinical trials;	68
(2) Cohort studies or case-control studies; 15	69
(3) Case series;	70
(4) Expert opinion. 15	71
(E) "Covered person" means a policyholder, subscriber, 15	72
enrollee, member, or individual covered by a health benefit 15	73
plan. "Covered person" does include the covered person's 15	74
authorized representative with regard to an internal appeal or 15	75

external review in accordance with division (C) of this section.	1576
"Covered person" does not include the covered person's	1577
representative in any other context.	1578
(F) "Covered benefits" or "benefits" means those health	1579
care services to which a covered person is entitled under the	1580
terms of a health benefit plan.	1581
(G) "Emergency medical condition" has the same meaning as	1582
in section 1753.28 of the Revised Code.	1583
(H) "Emergency services" has the same meaning as in	1584
section 1753.28 of the Revised Code.	1585
(I) "Evidence-based standard" means the conscientious,	1586
explicit, and judicious use of the current best evidence, based	1587
on a systematic review of the relevant research, in making	1588
decisions about the care of individuals.	1589
(J) "Facility" means an institution providing health care	1590
services, or a health care setting, including hospitals and	1591
other licensed inpatient centers, ambulatory, surgical,	1592
treatment, skilled nursing, residential treatment, diagnostic,	1593
laboratory, and imaging centers, and rehabilitation and other	1594
therapeutic health settings.	1595
(K) "Final adverse benefit determination" means an adverse	1596
benefit determination that is upheld at the completion of a	1597
health plan issuer's internal appeals process.	1598
(L) "Health benefit plan" means a policy, contract,	1599
certificate, or agreement offered by a health plan issuer to	1600
provide, deliver, arrange for, pay for, or reimburse any of the	1601
costs of health care services, including benefit plans marketed	1602
in the individual or group market by all associations, whether	1603
bona fide or non-bona fide. "Health benefit plan" also means a	1604

limited benefit plan, except as follows. "Health benefit plan"	1605
does not mean any of the following types of coverage: a policy,	1606
contract, certificate, or agreement that covers only a specified	1607
accident, accident only, credit, dental, disability income,	1608
long-term care, hospital indemnity, supplemental coverage, as	1609
described in section 3923.37 of the Revised Code, specified	1610
disease, or vision care; coverage issued as a supplement to	1611
liability insurance; insurance arising out of workers'	1612
compensation or similar law; automobile medical payment	1613
insurance; or insurance under which benefits are payable with or	1614
without regard to fault and which is statutorily required to be	1615
contained in any liability insurance policy or equivalent self-	1616
insurance; a medicare supplement policy of insurance, as defined	1617
by the superintendent of insurance by rule, coverage under a	1618
plan through medicare, medicaid, or the federal employees	1619
benefit program; any coverage issued under Chapter 55 of Title	1620
10 of the United States Code and any coverage issued as a	1621
supplement to that coverage.	1622
(M) "Health care professional" means a physician,	1623
psychologist, nurse practitioner, or other health care	1624
practitioner licensed, accredited, or certified to perform	1625
health care services consistent with state law.	1626

- (N) "Health care provider" or "provider" means a health 1627 care professional or facility. 1628
- (O) "Health care services" means services for the 1629 diagnosis, prevention, treatment, cure, or relief of a health 1630 condition, illness, injury, or disease. 1631
- (P) "Health plan issuer" means an entity subject to the 1632 insurance laws and rules of this state, or subject to the 1633 jurisdiction of the superintendent of insurance, that contracts, 1634

or offers to contract to provide, deliver, arrange for, pay for,	1635
or reimburse any of the costs of health care services under a	1636
health benefit plan, including a sickness and accident insurance	1637
company, a health insuring corporation, a fraternal benefit	1638
society, a self-funded multiple employer welfare arrangement, or	1639
a nonfederal, government health plan. "Health plan issuer"	1640
includes a third party administrator licensed under Chapter	1641
3959. of the Revised Code to the extent that the benefits that	1642
such an entity is contracted to administer under a health	1643
benefit plan are subject to the insurance laws and rules of this	1644
state or subject to the jurisdiction of the superintendent.	1645
(Q) "Health information" means information or data,	1646
whether oral or recorded in any form or medium, and personal	1647
facts or information about events or relationships that relates	1648
to all of the following:	1649
(1) The past, present, or future physical, mental, or	1650
behavioral health or condition of a covered person or a member	1651
of the covered person's family;	1652
(2) The provision of health care services or health-	1653
related benefits to a covered person;	1654
(3) Payment for the provision of health care services to	1655
or for a covered person.	1656
(R) "Independent review organization" means an entity that	1657
is accredited to conduct independent external reviews of adverse	1658
benefit determinations pursuant to section 3922.13 of the	1659
Revised Code.	1660
(S) "Medical or scientific evidence" means evidence found	1661
in any of the following sources:	1662

(1) Peer-reviewed scientific studies published in, or

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accepted for publication by, medical journals that meet	1664
nationally recognized requirements for scientific manuscripts	1665
and that submit most of their published articles for review by	1666
experts who are not part of the editorial staff;	1667
(2) Peer-reviewed medical literature, including literature	1668
relating to therapies reviewed and approved by a qualified	1669
institutional review board, biomedical compendia and other	1670
medical literature that meet the criteria of the national	1671
institutes of health's library of medicine for indexing in index	1672
medicus and elsevier science ltd. for indexing in excerpta	1673
medicus;	1674
(3) Medical journals recognized by the secretary of health	1675
and human services under section 1861(t)(2) of the federal	1676
social security act;	1677
(4) The following standard reference compendia:	1678
(a) The American hospital formulary service drug	1679
information;	1680
(b) Drug facts and comparisons;	1681
(c) The American dental association accepted dental	1682
therapeutics;	1683
(d) The United States pharmacopoeia drug information.	1684
(5) Findings, studies or research conducted by or under	1685
the auspices of a federal government agency or nationally	1686
recognized federal research institute, including any of the	1687
following:	1688
(a) The federal agency for health care research and	1689
quality;	1690

(b) The national institutes of health;	1691
(c) The national cancer institute;	1692
(d) The national academy of sciences;	1693
(e) The centers for medicare and medicaid services;	1694
(f) The federal food and drug administration;	1695
(g) Any national board recognized by the national	1696
institutes of health for the purpose of evaluating the medical	1697
value of health care services.	1698
(6) Any other medical or scientific evidence that is	1699
comparable.	1700
(T) "Person" has the same meaning as in section 3901.19 of	1701
the Revised Code.	1702
(U) "Protected health information" means health	1703
information related to the identity of an individual, or	1704
information that could reasonably be used to determine the	1705
identity of an individual.	1706
(V) "Rescind" means to retroactively cancel or discontinue	1707
coverage. "Rescind" does not include canceling or discontinuing	1708
coverage that only has a prospective effect or canceling or	1709
discontinuing coverage that is effective retroactively to the	1710
extent it is attributable to a failure to timely pay required	1711
premiums or contributions towards the cost of coverage.	1712
(W) "Retrospective review" means a review conducted after	1713
services have been provided to a covered person.	1714
(X) "Superintendent" means the superintendent of	1715
insurance.	1716
(Y) "Utilization review" has the same meaning as in	1717

section 1751.77 of the Revised Code.	1718
(Z) "Utilization review organization" has the same meaning	1719
as in section 1751.77 of the Revised Code.	1720
Sec. 3923.122. (A) Every policy of group sickness and	1721
accident insurance providing hospital, surgical, or medical	1722
expense coverage for other than specific diseases or accidents	1723
only, and delivered, issued for delivery, or renewed in this	1724
state on or after January 1, 1976, shall include a provision	1725
giving each insured the option to convert to the following:	1726
(1) In the case of an individual who is not a federally	1727
eligible individual, any of the individual policies of hospital,	1728
surgical, or medical expense insurance then being issued by the	1729
insurer with benefit limits not to exceed those in effect under	1730
the group policy+	1731
(2) In the case of a federally eligible individual, a	1732
basic or standard plan established in accordance with section	1733
3924.10 of the Revised Code or plans substantially similar to-	1734
the basic and standard plan in benefit design and scope of	1735
covered services. For purposes of division (A)(2) of this-	1736
section, the superintendent of insurance shall determine whether-	1737
a plan is substantially similar to the basic or standard plan in	1738
benefit design and scope of covered services.	1739
(B) An option for conversion to an individual policy shall	1740
be available without evidence of insurability to every insured,	1741
including any person eligible under division (D) of this	1742
	1740
section, who terminates employment or membership in the group	1743
section, who terminates employment or membership in the group holding the policy after having been continuously insured	1743

payment of at least the first quarterly premium not later than	1747
thirty-one days after the termination of coverage under the	1748
group policy, the insurer shall issue a converted policy on a	1749
form then available for conversion. The premium shall be in	1750
accordance with the insurer's table of premium rates in effect	1751
on the later of the following dates:	1752
(1) The effective date of the converted policy;	1753
(2) The date of application therefor; and shall be	1754
applicable to the class of risk to which each person covered	1755
belongs and to the form and amount of the policy at the person's	1756
then attained age. However, premiums charged federally eligible	1757
individuals may not exceed the amounts specified below:	1758
(a) For calendar years 2010 and 2011, an amount that is	1759
two times the base rate charged any other individual of a group-	1760
to which the insurer is currently accepting new business and for-	1761
which similar copayments and deductibles are applied;	1762
(b) For calendar year 2012 and every year thereafter, an	1763
amount that is one and one half times the base rate charged any	1764
other individual of a group to which the insurer is currently	1765
accepting new business and for which similar copayments and	1766
deductibles are applied, unless the superintendent of insurance	1767
determines that the amendments by this act to sections 3923.58-	1768
and 3923.581 of the Revised Code, have resulted in the market-	1769
wide average medical loss ratio for coverage sold to individual	1770
insureds and nonemployer group insureds in this state, including	1771
open enrollment insureds, to increase by more than five and one	1772
quarter percentage points during calendar year 2010. If the	1773
superintendent makes that determination, the premium limit-	1774
established by division (B)(2)(a) of this section shall remain-	1775
in effect.	1776

At the election of the insurer, a separate converted	1777
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policy may be issued to cover any dependent of an employee or	1778
member of the group.	1779
Except as provided in division (H) of this section, any	1780
converted policy shall become effective as of the day following	1781
the date of termination of insurance under the group policy.	1782
Any probationary or waiting period set forth in the	1783
converted policy is deemed to commence on the effective date of	1784
the insured's coverage under the group policy.	1785
(C) No insurer shall be required to issue a converted	1786
policy to any person who is, or is eligible to be, covered for	1787
benefits at least comparable to the group policy under:	1788
(1) Title XVIII of the Social Security Act, as amended or	1789
superseded;	1790
(2) Any act of congress or law under this or any other	1791
state of the United States that duplicates coverage offered	1792
under division (C)(1) of this section;	1793
(3) Any policy that duplicates coverage offered under	1794
division (C)(1) of this section;	1795
(4) Any other group sickness and accident insurance	1796
providing hospital, surgical, or medical expense coverage for	1797
other than specific diseases or accidents only.	1798
(D) The option for conversion shall be available:	1799
(1) Upon the death of the employee or member, to the	1800
surviving spouse with respect to such of the spouse and	1801
dependents as are then covered by the group policy;	1802
(2) To a child solely with respect to the child upon	1803

attaining the limiting age of coverage under the group policy	1804
while covered as a dependent thereunder;	1805
(3) Upon the divorce, dissolution, or annulment of the	1806
marriage of the employee or member, to the divorced spouse, or	1807
former spouse in the event of annulment, of such employee or	1808
member, or upon the legal separation of the spouse from such	1809
employee or member, to the spouse.	1810
Persons possessing the option for conversion pursuant to	1811
this division shall be considered members for the purposes of	1812
division (H) of this section.	1813
(E) If coverage is continued under a group policy on an	1814
employee following retirement prior to the time the employee is,	1815
or is eligible to be, covered by Title XVIII of the Social	1816
Security Act, the employee may elect, in lieu of the continuance	1817
of group insurance, to have the same conversion rights as would	1818
apply had the employee's insurance terminated at retirement by	1819
reason of termination of employment.	1820
(F) If the insurer and the group policyholder agree upon	1821
one or more additional plans of benefits to be available for	1822
converted policies, the applicant for the converted policy may	1823
elect such a plan in lieu of a converted policy.	1824
(G) The converted policy may contain provisions for	1825
avoiding duplication of benefits provided pursuant to divisions	1826
(C) $(1)$ , $(2)$ , $(3)$ , and $(4)$ of this section or provided under any	1827
other insured or noninsured plan or program.	1828
(H) If an employee or member becomes entitled to obtain a	1829
converted policy pursuant to this section, and if the employee	1830
or member has not received notice of the conversion privilege at	1831
least fifteen days prior to the expiration of the thirty-one-day	1832

conversion period provided in division (B) of this section, then	1833
the employee or member has an additional period within which to	1834
exercise the privilege. This additional period shall expire	1835
fifteen days after the employee or member receives notice, but	1836
in no event shall the period extend beyond sixty days after the	1837
expiration of the thirty-one-day conversion period.	1838
Written notice presented to the employee or member, or	1839
mailed by the policyholder to the last known address of the	1840
employee or member as indicated on its records, constitutes	1841
notice for the purpose of this division. In the case of a person	1842
who is eligible for a converted policy under division (D)(2) or	1843
(D)(3) of this section, a policyholder shall not be responsible	1844
for presenting or mailing such notice, unless such policyholder	1845
has actual knowledge of the person's eligibility for a converted	1846
policy.	1847
If an additional period is allowed by an employee or	1848
member for the exercise of a conversion privilege, and if	1849
written application for the converted policy, accompanied by at	1850
least the first quarterly premium, is made after the expiration	1851
least the first quarterly premium, is made after the expiration of the thirty-one-day conversion period, but within the	1851 1852
of the thirty-one-day conversion period, but within the	1852
of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance	1852 1853
of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy	1852 1853 1854
of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application.	1852 1853 1854 1855
of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application.  (I) The converted policy may provide that any hospital,	1852 1853 1854 1855
of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application.  (I) The converted policy may provide that any hospital, surgical, or medical expense benefits otherwise payable with	1852 1853 1854 1855 1856 1857

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(J) The converted policy may contain:

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(1) Any exclusion, reduction, or limitation contained in	1862
the group policy or customarily used in individual policies	1863
issued by the insurer;	1864
(2) Any provision permitted in this section;	1865
(2) Thus other provision not prohibited by low	1066
(3) Any other provision not prohibited by law.	1866
Any provision required or permitted in this section may be	1867
made a part of any converted policy by means of an endorsement	1868
or rider.	1869
(K) The time limit specified in a converted policy for	1870
certain defenses with respect to any person who was covered by a	1871
group policy shall commence on the effective date of such	1872
person's coverage under the group policy.	1873
(I) No incurre shell use deteriors in of health or the	107/
(L) No insurer shall use deterioration of health as the	1874
basis for refusing to renew a converted policy.	1875
(M) No insurer shall use age or health status as the basis	1876
for refusing to renew a converted policy.	1877
(N) A converted policy made available pursuant to this	1878
section shall, if delivery of the policy is to be made in this	1879
state, comply with this section. If delivery of a converted	1880
policy is to be made in another state, it may be on a form	1881
offered by the insurer in the jurisdiction where the delivery is	1882
to be made and which provides benefits substantially in	1883
compliance with those required in a policy delivered in this	1884
state.	1885
(O) As used in this section:	1886
(1) "Base rate" means, as to any health benefit plan that	1887
is issued by an insurer in the individual market, the lowest	1888
premium rate for new or existing business prescribed by the	1889

insurer for the same or similar coverage under a plan or	1890
arrangement covering any individual of a group with similar case	1891
characteristics.	1892
(2) "Federally eligible individual" means an eligible-	1893
individual as defined in 45 C.F.R. 148.103.	1894
Sec. 3923.57. Notwithstanding any provision of this	1895
chapter, every individual policy of sickness and accident	1896
insurance that is delivered, issued for delivery, or renewed in	1897
this state is subject to the following conditions, as	1898
applicable:	1899
(A) Pre-existing conditions provisions shall not exclude	1900
or limit coverage for a period beyond twelve months following-	1901
the policyholder's effective date of coverage and may only	1902
relate to conditions during the six months immediately preceding	1903
the effective date of coverage.	1904
(B) In determining whether a pre-existing conditions-	1905
provision applies to a policyholder or dependent, each policy	1906
shall credit the time the policyholder or dependent was covered	1907
under a previous policy, contract, or plan if the previous-	1908
coverage was continuous to a date not more than thirty days	1909
prior to the effective date of the new coverage, exclusive of	1910
any applicable service waiting period under the policy.	1911
$\frac{(C)}{(1)}$ Except as otherwise provided in division $\frac{(C)}{(A)}$ of	1912
this section, an insurer that provides an individual sickness	1913
and accident insurance policy to an individual shall renew or	1914
continue in force such coverage at the option of the individual.	1915
(2) An insurer may nonrenew or discontinue coverage of an	1916
individual in the individual market based only on one or more of	1917
the following reasons:	1918

(a) The individual failed to pay premiums or contributions	1919
in accordance with the terms of the policy or the insurer has	1920
not received timely premium payments.	1921
(b) The individual performed an act or practice that	1922
constitutes fraud or made an intentional misrepresentation of	1923
material fact under the terms of the policy.	1924
(c) The insurer is ceasing to offer coverage in the	1925
individual market in accordance with division $\frac{(B)}{(B)}$ of this	1926
section and the applicable laws of this state.	1927
(d) If the insurer offers coverage in the market through a	1928
network plan, the individual no longer resides, lives, or works	1929
in the service area, or in an area for which the insurer is	1930
authorized to do business; provided, however, that such coverage	1931
is terminated uniformly without regard to any health status-	1932
related factor of covered individuals.	1933
(e) If the coverage is made available in the individual	1934
market only through one or more bona fide associations, the	1935
membership of the individual in the association, on the basis of	1936
which the coverage is provided, ceases; provided, however, that	1937
such coverage is terminated under division $\frac{(C)}{(A)}(2)$ (e) of this	1938
section uniformly without regard to any health status-related	1939
factor of covered individuals.	1940
An insurer offering coverage to individuals solely through	1941
membership in a bona fide association shall not be deemed, by	1942
virtue of that offering, to be in the individual market for-	1943
purposes of sections 3923.58 and 3923.581 of the Revised Code.	1944
Such an insurer shall not be required to accept applicants for-	1945
coverage in the individual market pursuant to sections 3923.58	1946
and 3923.581 of the Revised Code unless the insurer also offers	1947

coverage to individuals other than through bona fide-	1948
associations.	1949
(3) An insurer may cancel or decide not to renew the	1950
coverage of a dependent of an individual if the dependent has	1951
performed an act or practice that constitutes fraud or made an	1952
intentional misrepresentation of material fact under the terms	1953
of the coverage and if the cancellation or nonrenewal is not	1954
based, either directly or indirectly, on any health status-	1955
related factor in relation to the dependent.	1956
(D)(B)(1) If an insurer decides to discontinue offering a	1957
particular type of health insurance coverage offered in the	1958
individual market, coverage of such type may be discontinued by	1959
the insurer if the insurer does all of the following:	1960
(a) Provides notice to each individual provided coverage	1961
of this type in such market of the discontinuation at least	1962
ninety days prior to the date of the discontinuation of the	1963
coverage;	1964
(b) Offers to each individual provided coverage of this	1965
type in such market, the option to purchase any other individual	1966
health insurance coverage currently being offered by the insurer	1967
for individuals in that market;	1968
(c) In exercising the option to discontinue coverage of	1969
this type and in offering the option of coverage under division	1970
$\frac{(D)}{(B)}(1)$ (b) of this section, acts uniformly without regard to	1971
any health status-related factor of covered individuals or of	1972
individuals who may become eligible for such coverage.	1973
(2) If an insurer elects to discontinue offering all	1974
health insurance coverage in the individual market in this	1975
state, health insurance coverage may be discontinued by the	1976

insurer only if both of the following apply:	1977
(a) The insurer provides notice to the department of	1978
insurance and to each individual of the discontinuation at least	1979
one hundred eighty days prior to the date of the expiration of	1980
the coverage.	1981
(b) All health insurance delivered or issued for delivery	1982
in this state in such market is discontinued and coverage under	1983
that health insurance in that market is not renewed.	1984
(3) In the event of a discontinuation under division $(D)$	1985
(B)(2) of this section in the individual market, the insurer	1986
shall not provide for the issuance of any health insurance	1987
coverage in the market and this state during the five-year	1988
period beginning on the date of the discontinuation of the last	1989
health insurance coverage not so renewed.	1990
$\frac{(E)-(C)}{(D)}$ Notwithstanding divisions $\frac{(C)-(A)}{(D)}$ and $\frac{(D)-(B)}{(D)}$ of	1991
this section, an insurer may, at the time of coverage renewal,	1992
modify the health insurance coverage for a policy form offered	1993
to individuals in the individual market if the modification is	1994
consistent with the law of this state and effective on a uniform	1995
basis among all individuals with that policy form.	1996
$\frac{(F)-(D)}{(D)}$ Such policies are subject to sections 2743 and	1997
2747 of the "Health Insurance Portability and Accountability Act	1998
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A.	1999
300gg-43 and 300gg-47, as amended.	2000
$\frac{(G)}{(E)}$ Sections 3924.031 and 3924.032 of the Revised Code	2001
shall apply to sickness and accident insurance policies offered	2002
in the individual market in the same manner as they apply to	2003
health benefit plans offered in the small employer market.	2004
In accordance with 45 C.F.R. 148.102, divisions $\frac{(C)}{(A)}$ to	2005

$\overline{\text{(G)}}$ of this section also apply to all group sickness and	2006
accident insurance policies that are not sold in connection with	2007
an employment-related group health plan and that provide more	2008
than short-term, limited duration coverage.	2009
In applying divisions $\frac{(C)-(A)}{(A)}$ to $\frac{(G)-(E)}{(B)}$ of this section	2010
with respect to health insurance coverage that is made available	2011
by an insurer in the individual market to individuals only	2012
through one or more associations, the term "individual" includes	2013
the association of which the individual is a member.	2014
For purposes of this section, any policy issued pursuant	2015
to division (C) of section 3923.13 of the Revised Code in	2016
connection with a public or private college or university	2017
student health insurance program is considered to be issued to a	2018
bona fide association.	2019
As used in this section, "bona fide association" has the	2020
same meaning as in section 3924.03 of the Revised Code, and	2021
"health status-related factor" and "network plan" have the same	2022
meanings as in section 3924.031 of the Revised Code.	2023
This section does not apply to any policy that provides	2024
coverage for specific diseases or accidents only, or to any	2025
hospital indemnity, medicare supplement, long-term care,	2026
disability income, one-time-limited-duration policy that is less	2027
than twelve months, or other policy that offers only	2028
supplemental benefits.	2029
Sec. 3923.571. Except as otherwise provided in section	2030
2721 of the "Health Insurance Portability and Accountability Act	2031
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A.	2032
300gg-21, as amended, the following conditions apply to all	2033
group policies of sickness and accident insurance that are sold	2034

in connection with an employment-related group health plan and	2035
that are not subject to section 3924.03 of the Revised Code:	2036
(A) Any such policy shall comply with the requirements of	2037
division (A) of section 3924.03 and section 3924.033 of the	2038
Revised Code.	2039
(B)(1) Except as provided in section 2712(b) to (e) of the	2040
"Health Insurance Portability and Accountability Act of 1996,"	2041
if an insurer offers coverage in the small or large group market	2042
in connection with a group policy, the insurer shall renew or	2043
continue in force such coverage at the option of the	2044
policyholder.	2045
(2) An insurer may cancel or decide not to renew the	2046
coverage of an employee or of a dependent of an employee if the	2047
employee or dependent, as applicable, has performed an act or	2048
practice that constitutes fraud or made an intentional	2049
misrepresentation of material fact under the terms of the	2050
coverage and if the cancellation or nonrenewal is not based,	2051
either directly or indirectly, on any health status-related	2052
factor in relation to the employee or dependent.	2053
As used in division (B)(2) of this section, "health	2054
status-related factor" has the same meaning as in section	2055
3924.031 of the Revised Code.	2056
(C)(1) No such policy, or insurer offering health	2057
insurance coverage in connection with such a policy, shall	2058
require any individual, as a condition of coverage or continued	2059
coverage under the policy, to pay a premium or contribution that	2060
is greater than the premium or contribution for a similarly	2061
situated individual covered under the policy on the basis of any	2062
health status-related factor in relation to the individual or to	2063

an individual covered under the policy as a dependent of the	2064
individual.	2065
(2) Nothing in division (C)(1) of this section shall be	2066
construed to restrict the amount that an employer may be charged	2067
for coverage under a group policy, or to prevent a group policy,	2068
and an insurer offering group health insurance coverage, from	2069
establishing premium discounts or rebates or modifying otherwise	2070
applicable copayments or deductibles in return for adherence to	2071
programs of health promotion and disease prevention.	2072
(D) Such policies shall provide for the special enrollment	2073
periods described in section 2701(f) of the "Health Insurance	2074
Portability and Accountability Act of 1996."	2075
(E) At least once in every twelve-month period, an insurer	2076
shall provide to all late enrollees, as defined in section	2077
3924.01 of the Revised Code, who are identified by the	2078
policyholder, the option to enroll in the group policy. The	2079
enrollment option shall be provided for a minimum period of	2080
thirty consecutive days. All delays of coverage imposed under	2081
the group policy, including any pre-existing condition exclusion-	2082
period or service waiting period, shall begin on the date the	2083
insurer receives notice of the late enrollee's application or	2084
request for coverage, and shall run concurrently with each	2085
other.	2086
Sec. 3923.85. (A) As used in this section, "cost sharing"	2087
means the cost to an individual insured under an individual or	2088
group policy of sickness and accident insurance or a public	2089
employee benefit plan according to any coverage limit,	2090
copayment, coinsurance, deductible, or other out-of-pocket	2091

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expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code	2093
and subject to division (D) of this section, no individual or	2094
group policy of sickness and accident insurance that is	2095
delivered, issued for delivery, or renewed in this state and no	2096
public employee benefit plan that is established or modified in	2097
this state shall fail to comply with either of the following:	2098
(1) The policy or plan shall not provide coverage or	2099
impose cost sharing for a prescribed, orally administered cancer	2100
medication on a less favorable basis than the coverage it	2101
provides or cost sharing it imposes for intraveneously	2102
administered or injected cancer medications.	2103
(2) The policy or plan shall not comply with division (B)	2104
(1) of this section by imposing an increase in cost sharing	2105
solely for orally administered, intravenously administered, or	2106
injected cancer medications.	2107
(C) Notwithstanding any provision of this section to the	2108
contrary, a policy or plan shall be deemed to be in compliance	2109
with this section if the cost sharing imposed under such a	2110
policy or plan for orally administered cancer treatments does	2111
not exceed one hundred dollars per prescription fill. The cost	2112
<pre>-sharing limit of one hundred dollars per prescription fill</pre>	2113
shall apply to a high deductible plan, as defined in 26 U.S.C.	2114
223, or a catastrophic plan, <u>described in division (D)(2) of</u>	2115
section 3902.43 of the Revised Code and as defined in 42 U.S.C.	2116
18022, only after the deductible has been met.	2117
(D)(1) The prohibitions in division (B) of this section do	2118
not preclude an individual or group policy of sickness and	2119
accident insurance or public employee benefit plan from	2120
requiring an insured or plan member to obtain prior	2121
authorization before orally administered cancer medication is	2122

dispensed to the insured or plan member.	2123
(2) Division (B) of this section does not apply to the	2124
offer or renewal of any individual or group policy of sickness	2125
and accident insurance that provides coverage for specific	2126
diseases or accidents only, or to any hospital indemnity,	2127
medicare supplement, disability income, or other policy that	2128
offers only supplemental benefits.	2129
(E) An insurer that offers any sickness and accident	2130
insurance or any public employee benefit plan that offers	2131
coverage for basic health care services is not required to	2132
comply with division (B) of this section if all of the following	2133
apply:	2134
(1) The insurer or plan submits documentation certified by	2135
an independent member of the American academy of actuaries to	2136
the superintendent of insurance showing that compliance with	2137
division (B)(1) of this section for a period of at least six	2138
months independently caused the insurer or plan's costs for	2139
claims and administrative expenses for the coverage of basic	2140
health care services to increase by more than one per cent per	2141
year.	2142
(2) The insurer or plan submits a signed letter from an	2143
independent member of the American academy of actuaries to the	2144
superintendent of insurance opining that the increase in costs	2145
described in division (E)(1) of this section could reasonably	2146
justify an increase of more than one per cent in the annual	2147
premiums or rates charged by the insurer or plan for the	2148
coverage of basic health care services.	2149
(3)(a) The superintendent of insurance makes the following	2150
determinations from the documentation and opinion submitted	2151

pursuant to divisions (E)(1) and (2) of this section:	2152
(i) Compliance with division (B)(1) of this section for a	2153
period of at least six months independently caused the insurer	2154
or plan's costs for claims and administrative expenses for the	2155
coverage of basic health care services to increase more than one	2156
per cent per year.	2157
(ii) The increase in costs reasonably justifies an	2158
increase of more than one per cent in the annual premiums or	2159
rates charged by the insurer or plan for the coverage of basic	2160
health care services.	2161
(b) Any determination made by the superintendent under	2162
division (E)(3) of this section is subject to Chapter 119. of	2163
the Revised Code.	2164
Sec. 3924.01. As used in sections 3924.01 to 3924.14	2165
3924.06 of the Revised Code:	2166
(A) "Actuarial certification" means a written statement	2167
prepared by a member of the American academy of actuaries, or by	2168
any other person acceptable to the superintendent of insurance,	2169
that states that, based upon the person's examination, a carrier	2170
offering health benefit plans to small employers is in	2171
compliance with sections 3924.01 to $\frac{3924.14}{3924.06}$ of the	2172
Revised Code. "Actuarial certification" shall include a review	2173
of the appropriate records of, and the actuarial assumptions and	2174
methods used by, the carrier relative to establishing premium	2175
rates for the health benefit plans.	2176
(B) "Adjusted average market premium price" means the	2177
average market premium price as determined by the board of	2178
directors of the Ohio health reinsurance program either on the	2179
basis of the arithmetic mean of all carriers' premium rates for-	2180

an OHC plan sold to groups with similar case characteristics by	2181
all carriers selling OHC plans in the state, or on any other	2182
equitable basis determined by the board.	2183
(C)—"Base premium rate" means, as to any health benefit	2184
plan that is issued by a carrier and that covers at least two	2185
but no more than fifty employees of a small employer, the lowest	2186
premium rate for a new or existing business prescribed by the	2187
carrier for the same or similar coverage under a plan or	2188
arrangement covering any small employer with similar case	2189
characteristics.	2190
(D) (C) "Carrier" means any sickness and accident	2191
insurance company or health insuring corporation authorized to	2192
issue health benefit plans in this state or a MEWA. A sickness	2193
and accident insurance company that owns or operates a health	2194
insuring corporation, either as a separate corporation or as a	2195
line of business, shall be considered as a separate carrier from	2196
that health insuring corporation for purposes of sections	2197
3924.01 to <u>3924.14</u> <u>3924.06</u> of the Revised Code.	2198
(E) (D) "Case characteristics" means, with respect to a	2199
small employer, the geographic area in which the employees work;	2200
the age and sex of the individual employees and their	2201
dependents; the appropriate industry classification as	2202
determined by the carrier; the number of employees and	2203
dependents; and such other objective criteria as may be	2204
established by the carrier. "Case characteristics" does not	2205
include claims experience, health status, or duration of	2206
coverage from the date of issue.	2207
(F) (E) "Dependent" means the spouse or child of an	2208
eligible employee, subject to applicable terms of the health	2209
benefits plan covering the employee.	2210

$\frac{(G)-(F)}{(F)}$ "Eligible employee" means an employee who works a	2211
normal work week of thirty or more hours. "Eligible employee"	2212
does not include a temporary or substitute employee, or a	2213
seasonal employee who works only part of the calendar year on	2214
the basis of natural or suitable times or circumstances.	2215
$\frac{(H)-(G)}{(H)}$ "Health benefit plan" means any hospital or	2216
medical expense policy or certificate or any health plan	2217
provided by a carrier, that is delivered, issued for delivery,	2218
renewed, or used in this state on or after the date occurring	2219
six months after November 24, 1995. "Health benefit plan" does	2220
not include policies covering only accident, credit, dental,	2221
disability income, long-term care, hospital indemnity, medicare	2222
supplement, specified disease, or vision care; coverage under a	2223
one-time-limited-duration policy that is less than twelve	2224
months; coverage issued as a supplement to liability insurance;	2225
insurance arising out of a workers' compensation or similar law;	2226
automobile medical-payment insurance; or insurance under which	2227
benefits are payable with or without regard to fault and which	2228
is statutorily required to be contained in any liability	2229
insurance policy or equivalent self-insurance.	2230
(I) (H) "Late enrollee" means an eligible employee or	2231
dependent who enrolls in a small employer's health benefit plan	2232
other than during the first period in which the employee or	2233
dependent is eligible to enroll under the plan or during a	2234
special enrollment period described in section 2701(f) of the	2235
"Health Insurance Portability and Accountability Act of 1996,"	2236
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as	2237
amended.	2238
(J) (I) "MEWA" means any "multiple employer welfare	2239
arrangement" as defined in section 3 of the "Federal Employee	2240

Retirement Income Security Act of 1974," 88 Stat. 832, 29	2241
U.S.C.A. 1001, as amended, except for any arrangement which is	2242
fully insured as defined in division (b)(6)(D) of section 514 of	2243
that act.	2244
(K) (J) "Midpoint rate" means, for small employers with	2245
similar case characteristics and plan designs and as determined	2246
by the applicable carrier for a rating period, the arithmetic	2247
average of the applicable base premium rate and the	2248
corresponding highest premium rate.	2249
(L) "Pre-existing conditions provision" means a policy	2250
provision that excludes or limits coverage for charges or-	2251
expenses incurred during a specified period following the	2252
insured's enrollment date as to a condition for which medical	2253
advice, diagnosis, care, or treatment was recommended or	2254
received during a specified period immediately preceding the	2255
enrollment date. Genetic information shall not be treated as-	2256
such a condition in the absence of a diagnosis of the condition	2257
related to such information.	2258
For purposes of this division, "enrollment date" means,	2259
with respect to an individual covered under a group health-	2260
benefit plan, the date of enrollment of the individual in the-	2261
plan or, if earlier, the first day of the waiting period for	2262
such enrollment.	2263
$\frac{(M)}{(K)}$ "Service waiting period" means the period of time	2264
after employment begins before an employee is eligible to be	2265
covered for benefits under the terms of any applicable health	2266
benefit plan offered by the small employer.	2267
$\frac{(N)(L)}{(1)}$ (1) "Small employer" means, in connection with a	2268
group health henefit plan and with respect to a calendar year	2260

and a plan year, an employer who employed an average of at least	2270
two but no more than fifty eligible employees on business days	2271
during the preceding calendar year and who employs at least two	2272
employees on the first day of the plan year.	2273
(2) For purposes of division (N)(1) of this section, all	2274
persons treated as a single employer under subsection (b), (c),	2275
(m), or (o) of section 414 of the "Internal Revenue Code of	2276
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be	2277
considered one employer. In the case of an employer that was not	2278
in existence throughout the preceding calendar year, the	2279
determination of whether the employer is a small or large	2280
employer shall be based on the average number of eligible	2281
employees that it is reasonably expected the employer will	2282
employ on business days in the current calendar year. Any	2283
reference in division (N) of this section to an "employer"	2284
includes any predecessor of the employer. Except as otherwise	2285
specifically provided, provisions of sections 3924.01 to $\frac{3924.14}{}$	2286
3924.06 of the Revised Code that apply to a small employer that	2287
has a health benefit plan shall continue to apply until the plan	2288
anniversary following the date the employer no longer meets the	2289
requirements of this division.	2290
(O) "OHC plan" means an Ohio health care plan, which is	2291
the basic, standard, or carrier reimbursement plan for small	2292
employers and individuals established in accordance with section	2293
3924.10 of the Revised Code.	2294
Sec. 3924.02. (A) An individual or group health benefit	2295
plan is subject to sections 3924.01 to <del>3924.14</del> <u>3924.06</u> of the	2296
Revised Code if it provides health care benefits covering at	2297
least two but no more than fifty employees of a small employer,	2298
and if it meets either of the following conditions:	2299

(1) Any portion of the premium or benefits is paid by a	2300
small employer, or any covered individual is reimbursed, whether	2301
through wage adjustments or otherwise, by a small employer for	2302
any portion of the premium.	2303
(2) The health benefit plan is treated by the employer or	2304
any of the covered individuals as part of a plan or program for	2305
purposes of section 106 or 162 of the "Internal Revenue Code of	2306
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.	2307
(B) Notwithstanding division (A) of this section,	2308
divisions $\frac{(D) \cdot (C)}{(C)}$ , $\frac{(E) \cdot (D)}{(C)}$ , $\frac{(F) \cdot (E)}{(E)}$ , and $\frac{(G) \cdot (F)}{(F)}$ of section	2309
3924.03 of the Revised Code and section 3924.04 of the Revised	2310
Code do not apply to health benefit policies that are not sold	2311
to owners of small businesses as an employment benefit plan.	2312
Such policies shall clearly state that they are not being sold	2313
as an employment benefit plan and that the owner of the business	2314
is not responsible, either directly or indirectly, for paying	2315
the premium or benefits.	2316
(C) Every health benefit plan offered or delivered by a	2317
carrier, other than a health insuring corporation, to a small	2318
employer is subject to sections 3923.23, 3923.231, 3923.232,	2319
3923.233, and 3923.234 of the Revised Code and any other	2320
provision of the Revised Code that requires the reimbursement,	2321
utilization, or consideration of a specific category of a	2322
licensed or certified health care practitioner.	2323
(D) Except as expressly provided in sections 3924.01 to	2324
3924.14—3924.06 of the Revised Code, no health benefit plan	2325
offered to a small employer is subject to any of the following:	2326

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(1) Any law that would inhibit any carrier from

contracting with providers or groups of providers with respect

to health care services or benefits;	2329
(2) Any law that would impose any restriction on the	2330
ability to negotiate with providers regarding the level or	2331
method of reimbursing care or services provided under the health	2332
benefit plan;	2333
(3) Any law that would require any carrier to either	2334
include a specific provider or class of provider when	2335
contracting for health care services or benefits, or to exclude	2336
any class of provider that is generally authorized by statute to	2337
provide such care.	2338
Sec. 3924.03. Except as otherwise provided in section 2721	2339
of the "Health Insurance Portability and Accountability Act of	2340
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-	2341
21, as amended, health benefit plans covering small employers	2342
are subject to the following conditions, as applicable:	2343
(A)(1) Pre-existing conditions provisions shall not-	2344
exclude or limit coverage for a period beyond twelve months, or	2345
eighteen months in the case of a late enrollee, following the	2346
individual's enrollment date and may only relate to a physical-	2347
or mental condition, regardless of the cause of the condition,	2348
for which medical advice, diagnosis, care, or treatment was	2349
recommended or received within the six months immediately	2350
preceding the enrollment date.	2351
Division (A) (1) of this section is subject to the	2352
exceptions set forth in section 2701(d) of the "Health Insurance-	2353
Portability and Accountability Act of 1996."	2354
(2) The period of any such pre-existing condition	2355
exclusion shall be reduced by the aggregate of the periods of	2356
creditable coverage, if any, applicable to the employee or	2357

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dependent as of the enrollment date.	2358
(3) A period of creditable coverage shall not be counted,	2359
with respect to enrollment of an individual under a group health	2360
benefit plan, if, after that period and before the enrollment	2361
date, there was a sixty-three-day period during all of which the	2362
individual was not covered under any creditable coverage.	2363
Subsections (c) (2) to (4) and (e) of section 2701 of the "Health	2364
Insurance Portability and Accountability Act of 1996" apply with	2365
respect to crediting previous coverage.	2366
(4) As used in division (A) of this section:	2367
(a) "Creditable coverage" has the same meaning as in-	2368
section 2701(c)(1) of the "Health Insurance Portability and	2369
Accountability Act of 1996."	2370
(b) "Enrollment date" means, with respect to an individual-	2371
covered under a group health benefit plan, the date of	2372
enrollment of the individual in the plan or, if earlier, the	2373
first day of the waiting period for such enrollment.	2374
(B)(1) Except as provided in section 2712(b) to (e) of the	2375
"Health Insurance Portability and Accountability Act of 1996,"	2376
if a carrier offers coverage in the small employer market in	2377
connection with a group health benefit plan, the carrier shall	2378
renew or continue in force such coverage at the option of the	2379
plan sponsor of the plan.	2380
(2) A carrier may cancel or decide not to renew the	2381
coverage of any eligible employee or of a dependent of an	2382
eligible employee if the employee or dependent, as applicable,	2383
has performed an act or practice that constitutes fraud or made	2384
an intentional misrepresentation of material fact under the	2385
terms of the coverage and if the cancellation or nonrenewal is	2386

not based, either directly or indirectly, on any health status-	2387
related factor in relation to the employee or dependent.	2388
As used in division $\frac{(B)}{(A)}(2)$ of this section, "health	2389
status-related factor" has the same meaning as in section	2390
3924.031 of the Revised Code.	2391
(C) (B) A carrier shall not exclude any eligible employee	2392
or dependent, who would otherwise be covered under a health	2393
benefit plan, on the basis of any actual or expected health	2394
condition of the employee or dependent.	2395
If, prior to November 24, 1995, a carrier excluded an	2396
eligible employee or dependent, other than a late enrollee, on	2397
the basis of an actual or expected health condition, the carrier	2398
shall, upon the initial renewal of the coverage on or after that	2399
date, extend coverage to the employee or dependent if all other	2400
eligibility requirements are met.	2401
$\frac{(D)}{(C)}$ No health benefit plan issued by a carrier shall	2402
limit or exclude, by use of a rider or amendment applicable to a	2403
specific individual, coverage by type of illness, treatment,	2404
medical condition, or accident, except for pre-existing	2405
conditions as permitted under division (A) of this section. If a	2406
health benefit plan that is delivered or issued for delivery	2407
prior to April 14, 1993, contains such limitations or	2408
exclusions, by use of a rider or amendment applicable to a	2409
specific individual, the plan shall eliminate the use of such	2410
riders or amendments within eighteen months after April 14,	2411
1993.	2412
(E)(D)(1) Except as provided in sections 3924.031 and	2413
3924.032 of the Revised Code, and subject to such rules as may	2414
be adopted by the superintendent of insurance in accordance with	2415

Chapter 119. of the Revised Code, a carrier shall offer and make	2416
available every health benefit plan that it is actively	2417
marketing to every small employer that applies to the carrier	2418
for such coverage.	2419
Division $\frac{(E)}{(D)}(1)$ of this section does not apply to a	2420
health benefit plan that a carrier makes available in the small	2421
employer market only through one or more bona fide associations.	2422
Division $\frac{(E)(D)}{(1)}$ of this section shall not be construed	2423
to preclude a carrier from establishing employer contribution	2424
rules or group participation rules for the offering of coverage	2425
in connection with a group health benefit plan in the small	2426
employer market, as allowed under the law of this state. As used	2427
in division $\frac{(E)}{(D)}(1)$ of this section, "employer contribution	2428
rule" means a requirement relating to the minimum level or	2429
amount of employer contribution toward the premium for	2430
enrollment of employees and dependents and "group participation	2431
rule" means a requirement relating to the minimum number of	2432
employees or dependents that must be enrolled in relation to a	2433
specified percentage or number of eligible individuals or	2434
employees of an employer.	2435
(2) Each health benefit plan, at the time of initial group	2436
enrollment, shall make coverage available to all the eligible	2437
employees of a small employer without a service waiting period.	2438
The decision of whether to impose a service waiting period shall	2439
be made by the small employer. Such waiting periods shall not be	2440
greater than ninety days.	2441
(3) Each health benefit plan shall provide for the special	2442
enrollment periods described in section 2701(f) of the "Health	2443
Insurance Portability and Accountability Act of 1996."	2444

(4) At least once in every twelve-month period, a carrier	2445
shall provide to all late enrollees who are identified by the	2446
small employer, the option to enroll in the health benefit plan.	2447
The enrollment option shall be provided for a minimum period of	2448
thirty consecutive days. All delays of coverage imposed under	2449
the health benefit plan, including any pre-existing condition	2450
exclusion period, affiliation period, or service waiting period,	2451
shall begin on the date the carrier receives notice of the late	2452
enrollee's application or request for coverage, and shall run	2453
concurrently with each other.	2454
$\frac{(F)-(E)}{(E)}$ The benefit structure of any health benefit plan	2455
may, at the time of coverage renewal, be changed by the carrier	2456
to make it consistent with the benefit structure contained in	2457
health benefit plans being marketed to new small employer	2458
groups. If the health benefit plan is available in the small	2459
employer market other than only through one or more bona fide	2460
associations, the modification must be consistent with the law	2461
of this state and effective on a uniform basis among small	2462
employer group plans.	2463
$\frac{(G)}{(F)}$ A carrier may obtain any facts and information	2464
necessary to apply this section, or supply those facts and	2465
information to any other third-party payer, without the consent	2466
of the beneficiary. Each person claiming benefits under a health	2467
benefit plan shall provide any facts and information necessary	2468
to apply this section.	2469
For purposes of this section, "bona fide association"	2470
means an association that has been actively in existence for at	2471
least five years; has been formed and maintained in good faith	2472
for purposes other than obtaining insurance; does not condition	2473

membership in the association on any health status-related

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factor, as defined in section 3924.031 of the Revised Code,	2475
relating to an individual, including an employee or dependent;	2476
makes health insurance coverage offered through the association	2477
available to all members regardless of any health status-related	2478
factor, as defined in section 3924.031 of the Revised Code,	2479
relating to such members or to individuals eligible for coverage	2480
through a member; does not make health insurance coverage	2481
offered through the association available other than in	2482
connection with a member of the association; and meets any other	2483
requirement imposed by the superintendent. To maintain its	2484
status as a "bona fide association," each association shall	2485
annually certify to the superintendent that it meets the	2486
requirements of this paragraph.	2487
Sec. 3924.033. (A) Each carrier, in connection with the	2488
offering of a health benefit plan to a small employer, shall	2489
disclose to the employer, as part of its solicitation and sales	2490
materials, the following information:	2491
(1) The provisions of the plan concerning the carrier's	2492
right to change premium rates and the factors that may affect	2493
changes in premium rates;	2494
(2) The provisions of the plan relating to renewability of	2495
coverage;	2496
(3) The provisions of the plan relating to any pre-	2497
existing condition exclusion;	2498
(4)—The benefits and premiums available under all health	2499
benefit plans for which the employer is qualified.	2500
(B) The information described in division (A) of this	2501
section shall be provided in a manner determined to be	2502
understandable by the average small employer, and in a manner	2503

sufficient to reasonably inform a small employer regarding the	2504
employer's rights and obligations under the health benefit plan.	2505
(C) Nothing in this section requires a carrier to disclose	2506
any information that is by law proprietary and trade secret	2507
information.	2508
Sec. 3924.06. (A) Compliance with the underwriting and	2509
rating requirements contained in sections 3924.01 to 3924.14	2510
3924.06 of the Revised Code shall be demonstrated through	2511
actuarial certification. Carriers offering health benefit plans	2512
to small employers shall file annually with the superintendent	2513
of insurance an actuarial certification stating that the	2514
underwriting and rating methods of the carrier do all of the	2515
following:	2516
(1) Comply with accepted actuarial practices;	2517
(2) Are uniformly applied to health benefit plans covering	2518
<pre>small employers;</pre>	2519
(3) Comply with the applicable provisions of sections	2520
3924.01 to <del>3924.14</del> <u>3924.06</u> of the Revised Code.	2521
(B) If a carrier has established a separate class of	2522
business for one or more small employer health care alliances in	2523
accordance with section 1731.09 of the Revised Code, this	2524
section shall apply in accordance with section 1731.09 of the	2525
Revised Code.	2526
(C) Carriers offering health benefit plans to small	2527
employers shall file premium rates with the superintendent in	2528
accordance with section 3923.02 of the Revised Code with respect	2529
to the carrier's sickness and accident insurance policies sold	2530
to small employers and in accordance with section 1751.12 of the	2531
Revised Code with respect to the carrier's health insuring	2532

corporation policies sold to small employers.	2533
Sec. 3924.51. (A) As used in this section:	2534
(1) "Child" means, in connection with any adoption or	2535
placement for adoption of the child, an individual who has not	2536
attained age eighteen as of the date of the adoption or	2537
placement for adoption.	2538
(2) "Health insurer" has the same meaning as in section	2539
3924.41 of the Revised Code.	2540
(3) "Placement for adoption" means the assumption and	2541
retention by a person of a legal obligation for total or partial	2542
support of a child in anticipation of the adoption of the child.	2543
The child's placement with a person terminates upon the	2544
termination of that legal obligation.	2545
(B) If an individual or group health plan of a health	2546
insurer makes coverage available for dependent children of	2547
participants or beneficiaries, the plan shall provide benefits	2548
to dependent children placed with participants or beneficiaries	2549
for adoption under the same terms and conditions as apply to the	2550
natural, dependent children of the participants and	2551
beneficiaries, irrespective of whether the adoption has become	2552
final.	2553
(C) A health plan described in division (B) of this	2554
section shall not restrict coverage under the plan of any	2555
dependent child adopted by a participant or beneficiary, or	2556
placed with a participant or beneficiary for adoption, solely on-	2557
the basis of a pre existing condition of the child at the time	2558
that the child would otherwise become eligible for coverage-	2559
under the plan, if the adoption or placement for adoption occurs-	2560
while the participant or beneficiary is eligible for coverage	2561

under the plan.	2562
Sec. 3924.73. (A) As used in this section:	2563
(1) "Health care insurer" means any person legally engaged	2564
in the business of providing sickness and accident insurance	2565
contracts in this state, a health insuring corporation organized	2566
under Chapter 1751. of the Revised Code, or any legal entity	2567
that is self-insured and provides health care benefits to its	2568
employees or members.	2569
(2) "Small employer" has the same meaning as in section	2570
3924.01 of the Revised Code.	2571
(B)(1) Subject to division (B)(2) of this section, nothing	2572
in sections 3924.61 to 3924.74 of the Revised Code shall be	2573
construed to limit the rights, privileges, or protections of	2574
employees or small employers under sections 3924.01 to 3924.14	2575
3924.06 of the Revised Code.	2576
(2) If any account holder enrolls or applies to enroll in	2577
a policy or contract offered by a health care insurer providing	2578
sickness and accident coverage that is more comprehensive than,	2579
and has a deductible amount that is less than, the coverage and	2580
deductible amount of the policy under which the account holder	2581
currently is enrolled, the health care insurer to which the	2582
account holder applies may subject the account holder to the	2583
same medical review, waiting periods, and underwriting	2584
requirements to which the health care insurer generally subjects	2585
other enrollees or applicants, unless the account holder enrolls	2586
or applies to enroll during a designated period of open	2587
enrollment.	2588
Section 2. That existing sections 1731.03, 1731.04,	2589
1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16,	2590

1751.18, 1751.58, 1751.69, 3901.381, 3922.01, 3923.122, 3923.57,	2591
3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06,	2592
3924.51, and 3924.73 of the Revised Code are hereby repealed.	2593
Section 3. That sections 1751.15, 3923.58, 3923.581,	2594
3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11,	2595
3924.111, 3924.12, 3924.13, and 3924.14 of the Revised Code are	2596
hereby repealed.	2597
Section 4. The amendments to sections 1751.16 and 3923.122	2598
of the Revised Code in Section 1 of this act, which were	2599
suspended by Section 3 of Sub. S.B. 9 of the 130th General	2600
Assembly and which suspension was extended by Section 610.53 of	2601
Am. Sub. H.B. 49 of the 132nd General Assembly, do not affect	2602
the suspension of those sections. If either or both sections	2603
1751.16 and 3923.122 of the Revised Code become operational,	2604
they will be so in either their form as amended by this act or	2605
as they are later amended.	2606
Section 5. This act applies to health benefit plans, as	2607
defined in section 3922.01 of the Revised Code, delivered,	2608
issued for delivery, modified, or renewed on or after the	2609
effective date of this section.	2610
Section 6. Section 1751.12 of the Revised Code is	2611
presented in this act as a composite of the section as amended	2612
by both H.B. 59 and H.B. 3 of the 130th General Assembly. The	2613
General Assembly, applying the principle stated in division (B)	2614
of section 1.52 of the Revised Code that amendments are to be	2615
harmonized if reasonably capable of simultaneous operation,	2616
finds that the composite is the resulting version of the section	2617
in effect prior to the effective date of the section as	2618
presented in this act.	2619