

As Introduced

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H. B. No. 438

Representatives Rader, Brownlee

Cosponsors: Representatives Grim, Piccolantonio, Somani, Jarrells, Robinson, McNally, Brennan, Brent, Upchurch, Abdullahi, White, E., Isaacsohn, Synenberg, Lett, Rogers, Russo, Miller, J.

To amend sections 1731.04, 1751.01, 1751.06,	1
1751.12, 1751.18, 1751.58, 1751.69, 3902.50,	2
3922.01, 3923.57, 3923.571, 3923.85, 3924.01,	3
3924.02, 3924.03, 3924.033, 3924.51, and	4
4125.041 and to enact sections 3902.55, 3902.56,	5
3902.57, and 3902.58 of the Revised Code	6
regarding health insurance premiums and benefits	7
and to name this act the Fair Access to Medical	8
Insurance for Local Youth and Families (FAMILY)	9
Act.	10

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

Section 1. That sections 1731.04, 1751.01, 1751.06,	11
1751.12, 1751.18, 1751.58, 1751.69, 3902.50, 3922.01, 3923.57,	12
3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.51,	13
and 4125.041 be amended and sections 3902.55, 3902.56, 3902.57,	14
and 3902.58 of the Revised Code be enacted to read as follows:	15

Sec. 1731.04. (A) An agreement between an alliance and an	16
insurer referred to in division (B) of section 1731.01 of the	17
Revised Code shall contain at least the following:	18

(1) A provision requiring the insurer to offer and sell to 19
small employers served or to be served by an alliance one or 20
more health benefit plan options for coverage of their eligible 21
employees and the eligible dependents and members of the 22
families of the eligible employees and, if applicable, such 23
members' eligible retirees and the eligible dependents and 24
members of the families of the retirees, subject to such 25
conditions and restrictions as may be set forth or incorporated 26
into the agreement; 27

(2) A brief description of each type of health benefit 28
plan option that is to be so offered and the conditions for the 29
modification, continuation, and termination of the coverage and 30
benefits thereunder; 31

(3) A statement of the eligibility requirements that an 32
employee or retiree must meet in order for the employee or 33
retiree to be eligible to obtain and retain coverage under any 34
health benefit plan option so offered and, if one of such 35
requirements is that an employee must regularly work for a 36
minimum number of hours per week, a statement of such minimum 37
number of hours, which minimum shall not exceed twenty-five 38
hours per week; 39

~~(4) A description of any pre-existing condition and~~ 40
~~waiting period rules;~~ 41

~~(5)~~ A statement of the premium rates or other charges that 42
apply to each health benefit plan option or a formula or method 43
of determining the rates or charges; 44

~~(6)~~ (5) A provision prescribing the minimum employer 45
contribution toward premiums or other charges required in order 46
to permit a small employer to obtain coverage under a health 47

benefit plan option offered under an alliance program; 48

~~(7)~~ (6) A provision requiring that each health benefit 49
plan under the alliance program must provide for the 50
continuation of coverage of participants of an enrolled small 51
employer so long as the small employer determines that such 52
person is a qualified beneficiary entitled to such coverage 53
pursuant to Part 6 of Title I of the "Federal Employee 54
Retirement Income Security Act of 1974," 88 Stat. 832, 29 55
U.S.C.A. 1001, and the laws of this state, and regulations or 56
rulings interpreting such provisions. Such coverage provided by 57
the insurer under the plan to participants shall comply with the 58
"Federal Employee Retirement Income Security Act of 1974" and 59
the relevant statutes, regulations, and rulings interpreting 60
that act, including provisions regarding types of coverage to be 61
provided, apportionments of limitations on coverage, 62
apportionments of deductibles, and the rights of qualified 63
beneficiaries to elect coverage options relating to types of 64
coverage and otherwise. 65

(B) An agreement between an alliance and an insurer 66
referred to in division (B) of section 1731.01 of the Revised 67
Code may contain provisions relating to, but not limited to, any 68
of the following: 69

(1) The application and enrollment process for a small 70
employer and related provisions pertaining to historical 71
experience, health statements, and underwriting standards; 72

(2) The minimum number of those employees eligible to be 73
participants that are required to participate in order to permit 74
a small employer to obtain coverage under a health benefit plan 75
option offered under the alliance program, which may vary with 76
the number of employees or those eligible to be participants in 77

respect of the small employer; 78

(3) A procedure for allowing an enrolled small employer to 79
change from one plan option to another under the alliance 80
program, subject to qualifying by size or otherwise under the 81
alliance program; 82

(4) The application of any risk-related pooling or 83
grouping programs and related premiums, conditions, reviews, and 84
alternatives offered by the insurer; 85

(5) The availability of a medicare supplement coverage 86
option for eligible participants who are covered by Parts A and 87
B of medicare, Title XVIII of the "Social Security Act," 49 88
Stat. 620 (1935), 42 U.S.C.A. 301; 89

(6) Relevant experience periods, enrollment periods, and 90
contract periods; 91

(7) Effective dates for coverage of eligible participants; 92

(8) Conditions under which denial or withdrawal of 93
coverage of participants or small employers and their employees 94
may occur by reason of falsification or misrepresentation of 95
material facts or criminal conduct toward the insurer, small 96
employer, or alliance under the program; 97

(9) Premium rate structures, which may be uniform or make 98
provision for age-specific rates, differentials based on number 99
of participants of an enrolled small employer, products and plan 100
options selected, and other factors, rate adjustments based on 101
consumer price indices, utilization, or other relevant factors, 102
notification of rate adjustments, and arbitration; 103

(10) Any responsibilities of the alliance for billing, 104
collection, and transmittal of premiums; 105

(11) Inclusion under the alliance program of small 106
employers that are members of other organizations described in 107
division (A) (1) of section 1731.01 of the Revised Code that 108
contract with the alliance for this purpose, and conditions 109
pertaining to those small employer members and to their 110
employees and retirees, and dependents and family members of 111
those employees or retirees, as applicable under the alliance 112
program; 113

(12) The agreement of the insurer to offer and sell one or 114
more health benefit plans to small employer members of another 115
small employer health care alliance that contracts with the 116
alliance for this purpose; 117

(13) Use of the health benefit plan options of the insurer 118
in the alliance program and use of the names of the alliance and 119
the insurer; 120

(14) Indemnification from claims and liability by reason 121
of acts or omissions of others; 122

(15) Ownership, use, availability, and maintenance of 123
confidentiality of data and records relating to the alliance 124
program; 125

(16) Utilization reports to be provided to the alliance by 126
the insurer; 127

(17) Such other provisions as may be agreed upon by the 128
alliance and the insurer to better provide for the articulation, 129
promotion, financing, and operation of the alliance program or a 130
health benefit plan under the program in furtherance of the 131
public purposes stated in section 1731.02 of the Revised Code. 132

(C) Neither an alliance program nor an agreement between 133
an alliance and an insurer is itself a policy or contract of 134

insurance, or a certificate, indorsement, rider, or application 135
forming any part of a policy, contract, or certificate of 136
insurance. Chapters 3905., 3933., and 3959. of the Revised Code 137
do not apply to an alliance program or to an agreement between 138
an alliance and an insurer thereunder, as such, or to the 139
functions of the alliance under an alliance program. 140

Sec. 1751.01. As used in this chapter: 141

(A)(1) "Basic health care services" means the following 142
services when medically necessary and, except for health care 143
plans offered in the large group market, the essential health 144
benefits identified in division (B)(1) of section 3902.57 of the 145
Revised Code: 146

(a) Physician's services, except when such services are 147
supplemental under division (B) of this section; 148

(b) Inpatient hospital services; 149

(c) Outpatient medical services; 150

(d) Emergency health services; 151

(e) Urgent care services; 152

(f) Diagnostic laboratory services and diagnostic and 153
therapeutic radiologic services; 154

(g) Diagnostic and treatment services, other than 155
prescription drug services, for biologically based mental 156
illnesses; 157

(h) Preventive health care services, including, but not 158
limited to, voluntary family planning services, infertility 159
services, periodic physical examinations, prenatal obstetrical 160
care, and well-child care; 161

(i) Routine patient care for patients enrolled in an 162
eligible cancer clinical trial pursuant to section 3923.80 of 163
the Revised Code. 164

"Basic health care services" does not include experimental 165
procedures. 166

Except as provided by divisions (A) (2) and (3) of this 167
section in connection with the offering of coverage for 168
diagnostic and treatment services for biologically based mental 169
illnesses, a health insuring corporation shall not offer 170
coverage for a health care service, defined as a basic health 171
care service by this division, unless it offers coverage for all 172
listed basic health care services. However, this requirement 173
does not apply to the coverage of beneficiaries enrolled in 174
medicare pursuant to a medicare contract, or to the coverage of 175
beneficiaries enrolled in the federal employee health benefits 176
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 177
medicaid recipients, or to the coverage of beneficiaries under 178
any federal health care program regulated by a federal 179
regulatory body, or to the coverage of beneficiaries under any 180
contract covering officers or employees of the state that has 181
been entered into by the department of administrative services. 182

(2) A health insuring corporation may offer coverage for 183
diagnostic and treatment services for biologically based mental 184
illnesses without offering coverage for all other basic health 185
care services. A health insuring corporation may offer coverage 186
for diagnostic and treatment services for biologically based 187
mental illnesses alone or in combination with one or more 188
supplemental health care services. However, a health insuring 189
corporation that offers coverage for any other basic health care 190
service shall offer coverage for diagnostic and treatment 191

services for biologically based mental illnesses in combination 192
with the offer of coverage for all other listed basic health 193
care services. 194

(3) A health insuring corporation that offers coverage for 195
basic health care services is not required to offer coverage for 196
diagnostic and treatment services for biologically based mental 197
illnesses in combination with the offer of coverage for all 198
other listed basic health care services if all of the following 199
apply: 200

(a) The health insuring corporation submits documentation 201
certified by an independent member of the American academy of 202
actuaries to the superintendent of insurance showing that 203
incurred claims for diagnostic and treatment services for 204
biologically based mental illnesses for a period of at least six 205
months independently caused the health insuring corporation's 206
costs for claims and administrative expenses for the coverage of 207
basic health care services to increase by more than one per cent 208
per year. 209

(b) The health insuring corporation submits a signed 210
letter from an independent member of the American academy of 211
actuaries to the superintendent of insurance opining that the 212
increase in costs described in division (A) (3) (a) of this 213
section could reasonably justify an increase of more than one 214
per cent in the annual premiums or rates charged by the health 215
insuring corporation for the coverage of basic health care 216
services. 217

(c) The superintendent of insurance makes the following 218
determinations from the documentation and opinion submitted 219
pursuant to divisions (A) (3) (a) and (b) of this section: 220

(i) Incurred claims for diagnostic and treatment services 221
for biologically based mental illnesses for a period of at least 222
six months independently caused the health insuring 223
corporation's costs for claims and administrative expenses for 224
the coverage of basic health care services to increase by more 225
than one per cent per year. 226

(ii) The increase in costs reasonably justifies an 227
increase of more than one per cent in the annual premiums or 228
rates charged by the health insuring corporation for the 229
coverage of basic health care services. 230

Any determination made by the superintendent under this 231
division is subject to Chapter 119. of the Revised Code. 232

(B) (1) "Supplemental health care services" means any 233
health care services other than basic health care services that 234
a health insuring corporation may offer, alone or in combination 235
with either basic health care services or other supplemental 236
health care services, and includes: 237

(a) Services of facilities for intermediate or long-term 238
care, or both; 239

(b) Dental care services; 240

(c) Vision care and optometric services including lenses 241
and frames; 242

(d) Podiatric care or foot care services; 243

(e) Mental health services, excluding diagnostic and 244
treatment services for biologically based mental illnesses; 245

(f) Short-term outpatient evaluative and crisis- 246
intervention mental health services; 247

(g) Medical or psychological treatment and referral	248
services for alcohol and drug abuse or addiction;	249
(h) Home health services;	250
(i) Prescription drug services;	251
(j) Nursing services;	252
(k) Services of a dietitian licensed under Chapter 4759.	253
of the Revised Code;	254
(l) Physical therapy services;	255
(m) Chiropractic services;	256
(n) Any other category of services approved by the	257
superintendent of insurance.	258
(2) If a health insuring corporation offers prescription	259
drug services under this division, the coverage shall include	260
prescription drug services for the treatment of biologically	261
based mental illnesses on the same terms and conditions as other	262
physical diseases and disorders.	263
(C) "Specialty health care services" means one of the	264
supplemental health care services listed in division (B) of this	265
section, when provided by a health insuring corporation on an	266
outpatient-only basis and not in combination with other	267
supplemental health care services.	268
(D) "Biologically based mental illnesses" means	269
schizophrenia, schizoaffective disorder, major depressive	270
disorder, bipolar disorder, paranoia and other psychotic	271
disorders, obsessive-compulsive disorder, and panic disorder, as	272
these terms are defined in the most recent edition of the	273
diagnostic and statistical manual of mental disorders published	274

by the American psychiatric association. 275

(E) "Closed panel plan" means a health care plan that 276
requires enrollees to use participating providers. 277

(F) "Compensation" means remuneration for the provision of 278
health care services, determined on other than a fee-for-service 279
or discounted-fee-for-service basis. 280

(G) "Contractual periodic prepayment" means the formula 281
for determining the premium rate for all subscribers of a health 282
insuring corporation. 283

(H) "Corporation" means a corporation formed under Chapter 284
1701. or 1702. of the Revised Code or the similar laws of 285
another state. 286

(I) "Emergency health services" means those health care 287
services that must be available on a seven-days-per-week, 288
twenty-four-hours-per-day basis in order to prevent jeopardy to 289
an enrollee's health status that would occur if such services 290
were not received as soon as possible, and includes, where 291
appropriate, provisions for transportation and indemnity 292
payments or service agreements for out-of-area coverage. 293

(J) "Enrollee" means any natural person who is entitled to 294
receive health care benefits provided by a health insuring 295
corporation. 296

(K) "Evidence of coverage" means any certificate, 297
agreement, policy, or contract issued to a subscriber that sets 298
out the coverage and other rights to which such person is 299
entitled under a health care plan. 300

(L) "Health care facility" means any facility, except a 301
health care practitioner's office, that provides preventive, 302

diagnostic, therapeutic, acute convalescent, rehabilitation, 303
mental health, intellectual disability, intermediate care, or 304
skilled nursing services. 305

(M) "Health care services" means basic, supplemental, and 306
specialty health care services. 307

(N) "Health delivery network" means any group of providers 308
or health care facilities, or both, or any representative 309
thereof, that have entered into an agreement to offer health 310
care services in a panel rather than on an individual basis. 311

(O) "Health insuring corporation" means a corporation, as 312
defined in division (H) of this section, that, pursuant to a 313
policy, contract, certificate, or agreement, pays for, 314
reimburses, or provides, delivers, arranges for, or otherwise 315
makes available, basic health care services, supplemental health 316
care services, or specialty health care services, or a 317
combination of basic health care services and either 318
supplemental health care services or specialty health care 319
services, through either an open panel plan or a closed panel 320
plan. 321

"Health insuring corporation" does not include a limited 322
liability company formed pursuant to former Chapter 1705. of the 323
Revised Code as that chapter existed prior to February 11, 2022, 324
or 1706. of the Revised Code, an insurer licensed under Title 325
XXXIX of the Revised Code if that insurer offers only open panel 326
plans under which all providers and health care facilities 327
participating receive their compensation directly from the 328
insurer, a corporation formed by or on behalf of a political 329
subdivision or a department, office, or institution of the 330
state, or a public entity formed by or on behalf of a board of 331
county commissioners, a county board of developmental 332

disabilities, an alcohol and drug addiction services board, a 333
board of alcohol, drug addiction, and mental health services, or 334
a community mental health board, as those terms are used in 335
Chapters 340. and 5126. of the Revised Code. Except as provided 336
by division (D) of section 1751.02 of the Revised Code, or as 337
otherwise provided by law, no board, commission, agency, or 338
other entity under the control of a political subdivision may 339
accept insurance risk in providing for health care services. 340
However, nothing in this division shall be construed as 341
prohibiting such entities from purchasing the services of a 342
health insuring corporation or a third-party administrator 343
licensed under Chapter 3959. of the Revised Code. 344

(P) "Intermediary organization" means a health delivery 345
network or other entity that contracts with licensed health 346
insuring corporations or self-insured employers, or both, to 347
provide health care services, and that enters into contractual 348
arrangements with other entities for the provision of health 349
care services for the purpose of fulfilling the terms of its 350
contracts with the health insuring corporations and self-insured 351
employers. 352

(Q) "Intermediate care" means residential care above the 353
level of room and board for patients who require personal 354
assistance and health-related services, but who do not require 355
skilled nursing care. 356

(R) "Medical record" means the personal information that 357
relates to an individual's physical or mental condition, medical 358
history, or medical treatment. 359

(S) (1) "Open panel plan" means a health care plan that 360
provides incentives for enrollees to use participating providers 361
and that also allows enrollees to use providers that are not 362

participating providers. 363

(2) No health insuring corporation may offer an open panel 364
plan, unless the health insuring corporation is also licensed as 365
an insurer under Title XXXIX of the Revised Code, the health 366
insuring corporation, on June 4, 1997, holds a certificate of 367
authority or license to operate under Chapter 1736. or 1740. of 368
the Revised Code, or an insurer licensed under Title XXXIX of 369
the Revised Code is responsible for the out-of-network risk as 370
evidenced by both an evidence of coverage filing under section 371
1751.11 of the Revised Code and a policy and certificate filing 372
under section 3923.02 of the Revised Code. 373

(T) "Osteopathic hospital" means a hospital registered 374
under section 3701.07 of the Revised Code that advocates 375
osteopathic principles and the practice and perpetuation of 376
osteopathic medicine by doing any of the following: 377

(1) Maintaining a department or service of osteopathic 378
medicine or a committee on the utilization of osteopathic 379
principles and methods, under the supervision of an osteopathic 380
physician; 381

(2) Maintaining an active medical staff, the majority of 382
which is comprised of osteopathic physicians; 383

(3) Maintaining a medical staff executive committee that 384
has osteopathic physicians as a majority of its members. 385

(U) "Panel" means a group of providers or health care 386
facilities that have joined together to deliver health care 387
services through a contractual arrangement with a health 388
insuring corporation, employer group, or other payor. 389

(V) "Person" has the same meaning as in section 1.59 of 390
the Revised Code, and, unless the context otherwise requires, 391

includes any insurance company holding a certificate of 392
authority under Title XXXIX of the Revised Code, any subsidiary 393
and affiliate of an insurance company, and any government 394
agency. 395

(W) "Premium rate" means any set fee regularly paid by a 396
subscriber to a health insuring corporation. A "premium rate" 397
does not include a one-time membership fee, an annual 398
administrative fee, or a nominal access fee, paid to a managed 399
health care system under which the recipient of health care 400
services remains solely responsible for any charges accessed for 401
those services by the provider or health care facility. 402

(X) "Primary care provider" means a provider that is 403
designated by a health insuring corporation to supervise, 404
coordinate, or provide initial care or continuing care to an 405
enrollee, and that may be required by the health insuring 406
corporation to initiate a referral for specialty care and to 407
maintain supervision of the health care services rendered to the 408
enrollee. 409

(Y) "Provider" means any natural person or partnership of 410
natural persons who are licensed, certified, accredited, or 411
otherwise authorized in this state to furnish health care 412
services, or any professional association organized under 413
Chapter 1785. of the Revised Code, provided that nothing in this 414
chapter or other provisions of law shall be construed to 415
preclude a health insuring corporation, health care 416
practitioner, or organized health care group associated with a 417
health insuring corporation from employing certified nurse 418
practitioners, certified nurse anesthetists, clinical nurse 419
specialists, certified nurse-midwives, pharmacists, dietitians, 420
physician assistants, dental assistants, dental hygienists, 421

optometric technicians, or other allied health personnel who are 422
licensed, certified, accredited, or otherwise authorized in this 423
state to furnish health care services. 424

(Z) "Provider sponsored organization" means a corporation, 425
as defined in division (H) of this section, that is at least 426
eighty per cent owned or controlled by one or more hospitals, as 427
defined in section 3727.01 of the Revised Code, or one or more 428
physicians licensed to practice medicine or surgery or 429
osteopathic medicine and surgery under Chapter 4731. of the 430
Revised Code, or any combination of such physicians and 431
hospitals. Such control is presumed to exist if at least eighty 432
per cent of the voting rights or governance rights of a provider 433
sponsored organization are directly or indirectly owned, 434
controlled, or otherwise held by any combination of the 435
physicians and hospitals described in this division. 436

(AA) "Solicitation document" means the written materials 437
provided to prospective subscribers or enrollees, or both, and 438
used for advertising and marketing to induce enrollment in the 439
health care plans of a health insuring corporation. 440

(BB) "Subscriber" means a person who is responsible for 441
making payments to a health insuring corporation for 442
participation in a health care plan, or an enrollee whose 443
employment or other status is the basis of eligibility for 444
enrollment in a health insuring corporation. 445

(CC) "Urgent care services" means those health care 446
services that are appropriately provided for an unforeseen 447
condition of a kind that usually requires medical attention 448
without delay but that does not pose a threat to the life, limb, 449
or permanent health of the injured or ill person, and may 450
include such health care services provided out of the health 451

insuring corporation's approved service area pursuant to 452
indemnity payments or service agreements. 453

Sec. 1751.06. Upon obtaining a certificate of authority as 454
required under this chapter, a health insuring corporation may 455
do all of the following: 456

(A) Enroll individuals and their dependents in either of 457
the following circumstances: 458

(1) The individual resides or lives in the approved 459
service area. 460

(2) The individual's place of employment is located in the 461
approved service area. 462

(B) Contract with providers and health care facilities for 463
the health care services to which enrollees are entitled under 464
the terms of the health insuring corporation's health care 465
contracts; 466

(C) Contract with insurance companies authorized to do 467
business in this state for insurance, indemnity, or 468
reimbursement against the cost of providing emergency and 469
nonemergency health care services for enrollees, subject to the 470
provisions set forth in this chapter and the limitations set 471
forth in the Revised Code; 472

(D) Contract with any person pursuant to the requirements 473
of division (A)(18) of section 1751.03 of the Revised Code for 474
managerial or administrative services, or for data processing, 475
actuarial analysis, billing services, or any other services 476
authorized by the superintendent of insurance. However, a health 477
insuring corporation shall not enter into a contract for any of 478
the services listed in this division with an insurance company 479
that is not authorized to engage in the business of insurance in 480

this state. 481

(E) Accept from governmental agencies, private agencies, 482
corporations, associations, groups, individuals, or other 483
persons, payments covering all or part of the costs of planning, 484
development, construction, and the provision of health care 485
services; 486

(F) Purchase, lease, construct, renovate, operate, or 487
maintain health care facilities, and their ancillary equipment, 488
and any property necessary in the transaction of the business of 489
the health insuring corporation; 490

(G) In the employer group market, impose an affiliation 491
period of not more than sixty days, or for late enrollees an 492
affiliation period of not more than ninety days, which period 493
begins on the individual's date of enrollment and runs 494
concurrently with any waiting period imposed under the coverage. 495
For purposes of this division, "affiliation period" means a 496
period of time which, under the terms of the coverage offered, 497
must expire before the coverage becomes effective. No health 498
care services or benefits need to be provided during an 499
affiliation period, and no periodic prepayments can be charged 500
for any coverage during that period. 501

(H) If a health insuring corporation offers coverage in 502
the small employer group market through a network plan, limit or 503
deny the coverage in accordance with section 3924.031 of the 504
Revised Code; 505

(I) Refuse to issue coverage in the small employer group 506
market pursuant to section 3924.032 of the Revised Code; 507

(J) Establish employer contribution rules or group 508
participation rules for the offering of coverage in connection 509

with a group contract in the small employer group market, as 510
provided in division ~~(E) (1)~~ (D) (1) of section 3924.03 of the 511
Revised Code. 512

Nothing in this section shall be construed as prohibiting 513
a health insuring corporation without other commercial 514
enrollment from contracting solely with federal health care 515
programs regulated by federal regulatory bodies. 516

Nothing in this section shall be construed to limit the 517
authority of a health insuring corporation to perform those 518
functions not otherwise prohibited by law. 519

Sec. 1751.12. (A) (1) No contractual periodic prepayment 520
and no premium rate for nongroup and conversion policies for 521
health care services, or any amendment to them, may be used by 522
any health insuring corporation at any time until the 523
contractual periodic prepayment and premium rate, or amendment, 524
have been filed with the superintendent of insurance, and shall 525
not be effective until the expiration of sixty days after their 526
filing unless the superintendent sooner gives approval. The 527
filing shall be accompanied by an actuarial certification in the 528
form prescribed by the superintendent. The superintendent shall 529
disapprove the filing, if the superintendent determines within 530
the sixty-day period that the contractual periodic prepayment or 531
premium rate, or amendment, is not in accordance with sound 532
actuarial principles or is not reasonably related to the 533
applicable coverage and characteristics of the applicable class 534
of enrollees. The superintendent shall notify the health 535
insuring corporation of the disapproval, and it shall thereafter 536
be unlawful for the health insuring corporation to use the 537
contractual periodic prepayment or premium rate, or amendment. 538

(2) No contractual periodic prepayment for group policies 539

for health care services shall be used until the contractual 540
periodic prepayment has been filed with the superintendent. The 541
filing shall be accompanied by an actuarial certification in the 542
form prescribed by the superintendent. The superintendent may 543
reject a filing made under division (A) (2) of this section at 544
any time, with at least thirty days' written notice to a health 545
insuring corporation, if the contractual periodic prepayment is 546
not in accordance with sound actuarial principles or is not 547
reasonably related to the applicable coverage and 548
characteristics of the applicable class of enrollees. 549

(3) At any time, the superintendent, upon at least thirty 550
days' written notice to a health insuring corporation, may 551
withdraw the approval given under division (A) (1) of this 552
section, deemed or actual, of any contractual periodic 553
prepayment or premium rate, or amendment, based on information 554
that either of the following applies: 555

(a) The contractual periodic prepayment or premium rate, 556
or amendment, is not in accordance with sound actuarial 557
principles. 558

(b) The contractual periodic prepayment or premium rate, 559
or amendment, is not reasonably related to the applicable 560
coverage and characteristics of the applicable class of 561
enrollees. 562

(4) Any disapproval under division (A) (1) of this section, 563
any rejection of a filing made under division (A) (2) of this 564
section, or any withdrawal of approval under division (A) (3) of 565
this section, shall be effected by a written notice, which shall 566
state the specific basis for the disapproval, rejection, or 567
withdrawal and shall be issued in accordance with Chapter 119. 568
of the Revised Code. 569

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

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

(2) The contractual periodic prepayment or premium rate is
filed with the superintendent prior to use and is accompanied by
documentation of approval from the United States department of
health and human services, the United States office of personnel
management, the department of medicaid, or the department of
administrative services.

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

and supported. 600

(D) (1) Copayments, cost sharing, and deductibles must be 601
reasonable and must not be a barrier to the necessary 602
utilization of services by enrollees. 603

(2) A health insuring corporation, in order to ensure that 604
copayments, cost sharing, and deductibles are reasonable and not 605
a barrier to the necessary utilization of basic health care 606
services by enrollees shall impose copayment charges, cost 607
sharing, and deductible charges that annually do not exceed 608
forty per cent of the total annual cost to the health insuring 609
corporation of providing all covered health care services when 610
applied to a standard population expected to be covered under 611
the filed product in question. The total annual cost of 612
providing a health care service is the cost to the health 613
insuring corporation of providing the health care service to its 614
enrollees as reduced by any applicable provider discount. This 615
requirement shall be demonstrated by an actuary who is a member 616
of the American academy of actuaries and qualified to provide 617
such certifications as described in the United States 618
qualification standards promulgated by the American academy of 619
actuaries pursuant to the code of professional conduct. 620

(3) For purposes of division (D) of this section, all of 621
the following apply: 622

(a) Copayments imposed by health insuring corporations in 623
connection with a high deductible health plan that is linked to 624
a health savings account are reasonable and are not a barrier to 625
the necessary utilization of services by enrollees. 626

(b) Division (D) (2) of this section does not apply to a 627
high deductible health plan that is linked to a health savings 628

account. 629

(c) Catastrophic-only plans, as described in division (D) 630
(2) of section 3902.57 of the Revised Code and defined under the 631
"Patient Protection and Affordable Care Act," 124 Stat. 119, 42 632
U.S.C. 18022 and any related regulations, are not subject to the 633
limits prescribed in division (D) of this section, provided that 634
such plans meet all applicable minimum federal requirements. 635

(E) A health insuring corporation shall not impose 636
lifetime maximums on basic health care services. However, a 637
health insuring corporation may establish a benefit limit for 638
inpatient hospital services that are provided pursuant to a 639
policy, contract, certificate, or agreement for supplemental 640
health care services. 641

(F) The superintendent may adopt rules allowing different 642
copayment, cost sharing, and deductible amounts for plans with a 643
medical savings account, health reimbursement arrangement, 644
flexible spending account, or similar account; 645

(G) A health insuring corporation may impose higher 646
copayment, cost sharing, and deductible charges under health 647
plans if requested by the group contract, policy, certificate, 648
or agreement holder, or an individual seeking coverage under an 649
individual health plan. This shall not be construed as requiring 650
the health insuring corporation to create customized health 651
plans for group contract holders or individuals. 652

(H) As used in this section, "health savings account" and 653
"high deductible health plan" have the same meanings as in the 654
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, 655
as amended. 656

Sec. 1751.18. (A) (1) No health insuring corporation shall 657

cancel or fail to renew the coverage of a subscriber or enrollee 658
because of any health status-related factor in relation to the 659
subscriber or enrollee, the subscriber's or enrollee's 660
requirements for health care services, or for any other reason 661
designated under rules adopted by the superintendent of 662
insurance. 663

(2) Unless otherwise required by state or federal law, no 664
health insuring corporation, or health care facility or provider 665
through which the health insuring corporation has made 666
arrangements to provide health care services, shall discriminate 667
against any individual with regard to enrollment, disenrollment, 668
or the quality of health care services rendered, on the basis of 669
the individual's race, color, sex, age, religion, military 670
status as defined in section 4112.01 of the Revised Code, or 671
status as a recipient of medicare or medicaid, or any health 672
status-related factor in relation to the individual. However, a 673
health insuring corporation shall not be required to accept a 674
recipient of medicare or medical assistance, if an agreement has 675
not been reached on appropriate payment mechanisms between the 676
health insuring corporation and the governmental agency 677
administering these programs. ~~Further, except as provided in~~ 678
~~section 1751.65 of the Revised Code, a health insuring~~ 679
~~corporation may reject an applicant for nongroup enrollment on~~ 680
~~the basis of any health status-related factor in relation to the~~ 681
~~applicant.~~ 682

(B) A health insuring corporation may cancel or decide not 683
to renew the coverage of an enrollee if the enrollee has 684
performed an act or practice that constitutes fraud or 685
intentional misrepresentation of material fact under the terms 686
of the coverage and if the cancellation or nonrenewal is not 687
based, either directly or indirectly, on any health status- 688

related factor in relation to the enrollee. 689

(C) An enrollee may appeal any action or decision of a 690
health insuring corporation taken pursuant to section 2742(b) to 691
(e) of the "Health Insurance Portability and Accountability Act 692
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 693
300gg-42, as amended. To appeal, the enrollee may submit a 694
written complaint to the health insuring corporation pursuant to 695
section 1751.19 of the Revised Code. The enrollee may, within 696
thirty days after receiving a written response from the health 697
insuring corporation, appeal the health insuring corporation's 698
action or decision to the superintendent. 699

(D) As used in this section, "health status-related 700
factor" means any of the following: 701

- (1) Health status; 702
- (2) Medical condition, including both physical and mental 703
illnesses; 704
- (3) Claims experience; 705
- (4) Receipt of health care; 706
- (5) Medical history; 707
- (6) Genetic information; 708
- (7) Evidence of insurability, including conditions arising 709
out of acts of domestic violence; 710
- (8) Disability. 711

Sec. 1751.58. Except as otherwise provided in section 2721 712
of the "Health Insurance Portability and Accountability Act of 713
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 714
300gg-21, as amended, the following conditions apply to all 715

group health insuring corporation contracts that are sold in 716
connection with an employment-related group health care plan and 717
that are not subject to section 3924.03 of the Revised Code: 718

(A) (1) Except as provided in section 2712(b) to (e) of the 719
"Health Insurance Portability and Accountability Act of 1996," 720
if a health insuring corporation offers coverage in the small or 721
large group market in connection with a group contract, the 722
corporation shall renew or continue in force such coverage at 723
the option of the contract holder. 724

(2) A health insuring corporation may cancel or decide not 725
to renew the coverage of any eligible employee or of a dependent 726
of an eligible employee under the group contract in accordance 727
with division (B) of section 1751.18 of the Revised Code. 728

(B) Such group contracts are subject to ~~division (A) (3) of~~ 729
~~section 3924.03 and sections 3924.033 and 3924.27 of the Revised~~ 730
Code. 731

(C) Such group contracts shall provide for the special 732
enrollment periods described in section 2701(f) of the "Health 733
Insurance Portability and Accountability Act of 1996." 734

(D) At least once in every twelve-month period, a health 735
insuring corporation shall provide to all late enrollees, as 736
defined in section 3924.01 of the Revised Code, who are 737
identified by the contract holder, the option to enroll in the 738
group contract. The enrollment option shall be provided for a 739
minimum period of thirty consecutive days. All delays of 740
coverage imposed under the group contract, including any 741
affiliation period, shall begin on the date the health insuring 742
corporation receives notice of the late enrollee's application 743
or request for coverage, and shall run concurrently with each 744

other. 745

Sec. 1751.69. (A) As used in this section, "cost sharing" 746
means the cost to an individual insured under an individual or 747
group health insuring corporation policy, contract, or agreement 748
according to any coverage limit, copayment, coinsurance, 749
deductible, or other out-of-pocket expense requirements imposed 750
by the policy, contract, or agreement. 751

(B) Notwithstanding section 3901.71 of the Revised Code 752
and subject to division (D) of this section, no individual or 753
group health insuring corporation policy, contract, or agreement 754
providing basic health care services or prescription drug 755
services that is delivered, issued for delivery, or renewed in 756
this state, if the policy, contract, or agreement provides 757
coverage for cancer chemotherapy treatment, shall fail to comply 758
with either of the following: 759

(1) The policy, contract, or agreement shall not provide 760
coverage or impose cost sharing for a prescribed, orally 761
administered cancer medication on a less favorable basis than 762
the coverage it provides or cost sharing it imposes for 763
intravenously administered or injected cancer medications. 764

(2) The policy, contract, or agreement shall not comply 765
with division (B)(1) of this section by imposing an increase in 766
cost sharing solely for orally administered, intravenously 767
administered, or injected cancer medications. 768

(C) Notwithstanding any provision of this section to the 769
contrary, an individual or group health insuring corporation 770
policy, contract, or agreement shall be deemed to be in 771
compliance with this section if the cost sharing imposed under 772
such a policy, contract, or agreement for orally administered 773

cancer treatments does not exceed one hundred dollars per 774
prescription fill. The cost _sharing limit of one hundred 775
dollars per prescription fill shall apply to a high deductible 776
plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as 777
described in division (D) (2) of section 3902.57 of the Revised 778
Code and defined in 42 U.S.C. 18022, only after the deductible 779
has been met. 780

(D) The prohibitions in division (B) of this section do 781
not preclude an individual or group health insuring corporation 782
policy, contract, or agreement from requiring an enrollee to 783
obtain prior authorization before orally administered cancer 784
medication is dispensed to the enrollee. 785

(E) A health insuring corporation that offers coverage for 786
basic health care services is not required to comply with 787
division (B) of this section if all of the following apply: 788

(1) The health insuring corporation submits documentation 789
certified by an independent member of the American academy of 790
actuaries to the superintendent of insurance showing that 791
compliance with division (B) (1) of this section for a period of 792
at least six months independently caused the health insuring 793
corporation's costs for claims and administrative expenses for 794
the coverage of basic health care services to increase by more 795
than one per cent per year. 796

(2) The health insuring corporation submits a signed 797
letter from an independent member of the American academy of 798
actuaries to the superintendent of insurance opining that the 799
increase in costs described in division (E) (1) of this section 800
could reasonably justify an increase of more than one per cent 801
in the annual premiums or rates charged by the health insuring 802
corporation for the coverage of basic health care services. 803

(3) (a) The superintendent of insurance makes the following 804
determinations from the documentation and opinion submitted 805
pursuant to divisions (E) (1) and (2) of this section: 806

(i) Compliance with division (B) (1) of this section for a 807
period of at least six months independently caused the health 808
insuring corporation's costs for claims and administrative 809
expenses for the coverage of basic health care services to 810
increase more than one per cent per year. 811

(ii) The increase in costs reasonably justifies an 812
increase of more than one per cent in the annual premiums or 813
rates charged by the health insuring corporation for the 814
coverage of basic health care services. 815

(b) Any determination made by the superintendent under 816
division (E) (3) of this section is subject to Chapter 119. of 817
the Revised Code. 818

Sec. 3902.50. As used in sections 3902.50 to 3902.72 of 819
the Revised Code: 820

(A) "Ambulance" has the same meaning as in section 4765.01 821
of the Revised Code. 822

(B) "Clinical laboratory services" has the same meaning as 823
in section 4731.65 of the Revised Code. 824

(C) "Cost sharing" means the cost to a covered person 825
under a health benefit plan according to any copayment, 826
coinsurance, deductible, or other out-of-pocket expense 827
requirement. 828

(D) "Covered" or "coverage" means the provision of 829
benefits related to health care services to a covered person in 830
accordance with a health benefit plan. 831

(E) "Covered person," "health benefit plan," "health care services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(F) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

(G) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.

(H) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(2) Treatment necessary to stabilize an emergency medical condition;

(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(I) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

(J) "Pharmacy benefit manager" has the same meaning as in section 3959.01 of the Revised Code.

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

(L) "Prior authorization requirement" means any practice 859
implemented by a health plan issuer in which coverage of a 860
health care service, device, or drug is dependent upon a covered 861
person or a provider obtaining approval from the health plan 862
issuer prior to the service, device, or drug being performed, 863
received, or prescribed, as applicable. "Prior authorization 864
requirement" includes prospective or utilization review 865
procedures conducted prior to providing a health care service, 866
device, or drug. 867

~~(L)~~ (M) "Unanticipated out-of-network care" means health 868
care services, including clinical laboratory services, that are 869
covered under a health benefit plan and that are provided by an 870
out-of-network provider when either of the following conditions 871
applies: 872

(1) The covered person did not have the ability to request 873
such services from an in-network provider. 874

(2) The services provided were emergency services. 875

Sec. 3902.55. (A) With respect to the premium rate charged 876
by a health plan issuer for a health benefit plan offered in the 877
individual or small group market, all of the following apply: 878

(1) The premium rate shall vary with respect to the health 879
benefit plan involved only by the following: 880

(a) Whether the health benefit plan covers an individual 881
or family; 882

(b) Rating area, as established in accordance with 883
division (C) (1) of this section; 884

(c) Age, except that such rate shall not vary by more than 885
three to one for adults; 886

(d) Tobacco use, except that such rate shall not vary by 887
more than one and one-half to one. 888

(2) The premium rate shall not vary with respect to the 889
health benefit plan involved by any other factor not described 890
in division (A) of this section. 891

(B) With respect to family coverage under a health benefit 892
plan, the rating variations permitted under divisions (A) (1) (c) 893
and (d) of this section shall be applied based on the portion of 894
the premium that is attributable to each family member covered 895
under the health benefit plan. 896

(C) The superintendent of insurance shall adopt rules to 897
do the following: 898

(1) Establish one or more rating areas within the state; 899

(2) Define the permissible age bands for rating purposes 900
under division (A) (3) of this section. 901

(D) A health plan issuer shall not establish lifetime or 902
annual limits on the dollar value of benefits described in 903
section 3902.57 of the Revised Code for any covered person. 904

Sec. 3902.56. (A) Every individual health benefit plan 905
shall accept every individual in this state who applies for 906
coverage and every group health benefit plan shall accept every 907
employer in this state that applies for coverage, regardless of 908
whether any individual or employee has a preexisting condition. 909
A health benefit plan may restrict enrollment in coverage to 910
open or special enrollment periods under division (C) of this 911
section. 912

(B) A health plan issuer shall not impose any preexisting 913
condition exclusion on any person. 914

(C) (1) The superintendent of insurance shall adopt rules 915
to ensure that each individual health benefit plan has open 916
enrollment during a statewide open enrollment period to allow 917
individuals, including individuals who are not covered persons, 918
to enroll in the health benefit plan. 919

(2) A health plan issuer shall provide special enrollment 920
periods for individuals who lose coverage as a result of a 921
qualifying event under 42 U.S.C. 9801(f) or 29 U.S.C. 1163. 922

Sec. 3902.57. (A) For purposes of this section, "essential 923
health benefits package" means, with respect to a health benefit 924
plan, coverage that does all of the following: 925

(1) Provides for the essential health benefits defined by 926
the superintendent of insurance under division (B) of this 927
section; 928

(2) Limits cost sharing for such coverage in accordance 929
with division (C) of this section; 930

(3) Provides the level of coverage described in division 931
(D) of this section. 932

(B) (1) Subject to division (B) (2) of this section, the 933
superintendent shall define the essential health benefits, 934
except that such benefits shall include at least the following 935
general categories and the items and services covered within the 936
categories: 937

(a) Ambulatory patient services; 938

(b) Emergency services; 939

(c) Hospitalization; 940

(d) Maternity and newborn care; 941

(e) Mental health and substance use disorder services, 942
including behavioral health treatment; 943

(f) Prescription drugs; 944

(g) Rehabilitative and habilitative services and devices; 945

(h) Laboratory services; 946

(i) Preventive and wellness services and chronic disease 947
management; 948

(j) Pediatric services, including oral, dental, and vision 949
care. 950

(2) (a) The superintendent shall ensure that the scope of 951
the essential health benefits under division (B) (1) of this 952
section is equal to the scope of benefits provided under a 953
typical employer plan, as determined by the superintendent. To 954
inform this determination, the superintendent shall conduct a 955
survey of employer-sponsored coverage to determine the benefits 956
typically covered by employers, including multi-employer plans. 957

(b) In defining the essential health benefits described in 958
division (B) (1) of this section, and in revising the benefits 959
under division (B) (3) (g) of this section, the superintendent 960
shall submit a report to the general assembly containing a 961
certification that such essential health benefits meet the 962
requirements described in division (B) (2) (a) of this section. 963

(3) In defining the essential health benefits under 964
division (B) (1) of this section, the superintendent shall do all 965
of the following: 966

(a) Ensure that such essential health benefits reflect an 967
appropriate balance among the categories described in division 968
(B) (1) of this section, so that benefits are not unduly weighted 969

toward any category; 970

(b) Not make coverage decisions, determine reimbursement 971
rates, establish incentive programs, or design benefits in ways 972
that discriminate against individuals because of their age, 973
disability, or expected length of life; 974

(c) Take into account the health care needs of diverse 975
segments of the population, including women, children, persons 976
with disabilities, and other groups; 977

(d) Ensure that health benefits established as essential 978
not be subject to denial to individuals against their wishes on 979
the basis of the individuals' age or expected length of life or 980
of the individuals' present or predicted disability, degree of 981
medical dependency, or quality of life; 982

(e) Provide that a qualified health benefit plan shall not 983
be treated as providing coverage for the essential health 984
benefits described in division (B)(1) of this section unless the 985
plan does both of the following: 986

(i) Provides that coverage for emergency services, as 987
defined in section 3923.65 of the Revised Code, will be provided 988
without imposing any requirement under the plan for prior 989
authorization of services or any limitation on coverage where 990
the provider of services does not have a contractual 991
relationship with the plan for the providing of services that is 992
more restrictive than the requirements or limitations that apply 993
to emergency services received from providers who do have such a 994
contractual relationship with the plan; 995

(ii) Provides that if emergency services are provided out- 996
of-network, the cost-sharing requirement is the same requirement 997
that would apply if such services were provided in-network. 998

(f) Periodically review the essential health benefits 999
under division (B) (1) of this section and provide a report to 1000
the general assembly and the public that contains all of the 1001
following: 1002

(i) An assessment of whether covered persons are facing 1003
any difficulty accessing needed services for reasons of coverage 1004
or cost; 1005

(ii) An assessment of whether the essential health 1006
benefits need to be modified or updated to account for changes 1007
in medical evidence or scientific advancement; 1008

(iii) Information on how the essential health benefits 1009
will be modified to address any such gaps in access or changes 1010
in the evidence base; 1011

(iv) An assessment of the potential of additional or 1012
expanded benefits to increase costs and the interactions between 1013
the addition or expansion of benefits and reductions in existing 1014
benefits to meet the requirements of division (B) (2) (a) of this 1015
section. 1016

(g) Periodically update the essential health benefits 1017
under division (B) (1) of this section to address any gaps in 1018
access to coverage or changes in the evidence base the 1019
superintendent identifies in the review conducted under division 1020
(B) (3) (f) of this section. 1021

(4) Nothing in this section shall be construed to prohibit 1022
a health benefit plan from providing benefits in excess of the 1023
essential health benefits described in this section. 1024

(C) (1) A health plan issuer shall not require cost sharing 1025
in an amount greater than seven thousand nine hundred dollars 1026
for self-only coverage and fifteen thousand eight hundred 1027

dollars for other than self-only coverage for plan years 1028
beginning after the effective date of this section. 1029

(2) For plan years beginning in a calendar year after the 1030
effective date of this section, the cost-sharing limit shall be 1031
as follows: 1032

(a) In the case of self-only coverage, be equal to the 1033
dollar amount in division (C) (1) of this section, increased by 1034
the product of that amount and the premium adjustment percentage 1035
under division (C) (3) of this section for the calendar year; 1036

(b) In the case of other than self-only coverage, twice 1037
the amount in effect under division (C) (2) (a) of this section. 1038
If the amount of any increase under division (C) (2) (a) of this 1039
section is not a multiple of fifty dollars, such increase shall 1040
be rounded to the next lowest multiple of fifty dollars. 1041

(3) The premium adjustment percentage for any calendar 1042
year shall be the percentage by which the average per capita 1043
premium for health benefit plans in this state for the preceding 1044
calendar year, as estimated by the superintendent not later than 1045
the first day of October of such preceding calendar year, 1046
exceeds such average per capita premium for 2025, as determined 1047
by the superintendent. 1048

(D) (1) (a) Except as provided in division (D) (2) of this 1049
section, a health benefit plan shall provide a level of coverage 1050
that is designed to provide benefits that are actuarially 1051
equivalent to sixty per cent of the full actuarial value of the 1052
benefits provided under the plan. 1053

(b) Under rules issued by the superintendent, the level of 1054
coverage of a plan shall be determined on the basis that the 1055
essential health benefits described in division (B) (1) of this 1056

section shall be provided to a standard population, without 1057
regard to the population the plan may actually provide benefits 1058
to. 1059

(2) A health benefit plan that does not provide the level 1060
of coverage described in division (D) (1) of this section shall 1061
be considered as meeting the requirements of that division with 1062
respect to any plan year if both of the following apply: 1063

(a) An individual is only eligible to enroll in the health 1064
benefit plan if the individual meets either of the following 1065
conditions: 1066

(i) The individual has not attained the age of thirty 1067
before the beginning of the plan year. 1068

(ii) The individual meets a hardship exemption as 1069
determined by the superintendent. 1070

(b) The health benefit plan provides both of the 1071
following: 1072

(i) Except as provided in division (D) (2) (b) (ii) of this 1073
section, the essential health benefits listed in division (B) (1) 1074
of this section, except that the health benefit plan provides no 1075
benefits for any plan year until the individual has incurred 1076
cost-sharing expenses in an amount equal to the annual 1077
limitation in effect under division (C) of this section for the 1078
plan year except as provided for in section 3902.58 of the 1079
Revised Code; 1080

(ii) Coverage for at least three primary care visits. 1081

(3) If a health plan issuer offers a health benefit plan 1082
described in division (D) (2) of this section, the issuer shall 1083
only offer the plan in the individual market. 1084

(E) The requirements of this section do not apply to 1085
health benefit plans offered in the large group market. 1086

(F) Nothing in this section is subject to the requirements 1087
of section 3901.71 of the Revised Code. 1088

Sec. 3902.58. (A) Notwithstanding section 3901.71 of the 1089
Revised Code, a health benefit plan shall provide coverage for 1090
and shall not impose any cost-sharing requirements for the 1091
following: 1092

(1) Evidence-based items or services that have in effect a 1093
rating of "A" or "B" in the current recommendations of the 1094
United States preventive services task force; 1095

(2) Immunizations that have in effect a recommendation 1096
from the advisory committee on immunization practices of the 1097
United States centers for disease control and prevention with 1098
respect to the individual involved; 1099

(3) With respect to infants, children, and adolescents, 1100
evidence-informed preventive care and screenings provided for in 1101
the comprehensive guidelines supported by the United States 1102
health resources and services administration; 1103

(4) With respect to women, such additional preventive care 1104
and screenings not described in division (A)(1) of this section 1105
as provided for in comprehensive guidelines supported by the 1106
United States health resources and services administration. 1107

(B) The superintendent shall adopt rules to implement 1108
sections 3902.50 to 3902.58 of the Revised Code. 1109

(C) As used in this section, "preventive care" means 1110
medical services based on current, peer-reviewed scientific 1111
evidence, and consistent with guidelines from broadly 1112

recognized, nonpartisan, professional medical organizations. The 1113
scope of "preventive care" shall not be narrowed unless 1114
justified by a transparent, scientific review. 1115

Sec. 3922.01. As used in this chapter: 1116

(A) "Adverse benefit determination" means a decision by a 1117
health plan issuer: 1118

(1) To deny, reduce, or terminate a requested health care 1119
service or payment in whole or in part, including all of the 1120
following: 1121

(a) A determination that the health care service does not 1122
meet the health plan issuer's requirements for medical 1123
necessity, appropriateness, health care setting, level of care, 1124
or effectiveness, including experimental or investigational 1125
treatments; 1126

(b) A determination of an individual's eligibility for 1127
individual health insurance coverage, including coverage offered 1128
to individuals through a nonemployer group, to participate in a 1129
plan or health insurance coverage; 1130

(c) A determination that a health care service is not a 1131
covered benefit; 1132

(d) The imposition of an exclusion, including exclusions 1133
for ~~pre-existing conditions~~, source of injury, network, or any 1134
other limitation on benefits that would otherwise be covered. 1135

(2) Not to issue individual health insurance coverage to 1136
an applicant, including coverage offered to individuals through 1137
a nonemployer group; 1138

(3) To rescind coverage on a health benefit plan. 1139

(B) "Ambulatory review" has the same meaning as in section 1140
1751.77 of the Revised Code. 1141

(C) "Authorized representative" means an individual who 1142
represents a covered person in an internal appeal or external 1143
review process of an adverse benefit determination who is any of 1144
the following: 1145

(1) A person to whom a covered individual has given 1146
express, written consent to represent that individual in an 1147
internal appeals process or external review process of an 1148
adverse benefit determination; 1149

(2) A person authorized by law to provide substituted 1150
consent for a covered individual; 1151

(3) A family member or a treating health care 1152
professional, but only when the covered person is unable to 1153
provide consent. 1154

(D) "Best evidence" means evidence based on all of the 1155
following sources, listed according to priority, as they are 1156
available: 1157

(1) Randomized clinical trials; 1158

(2) Cohort studies or case-control studies; 1159

(3) Case series; 1160

(4) Expert opinion. 1161

(E) "Covered person" means a policyholder, subscriber, 1162
enrollee, member, or individual covered by a health benefit 1163
plan. "Covered person" does include the covered person's 1164
authorized representative with regard to an internal appeal or 1165
external review in accordance with division (C) of this section. 1166

"Covered person" does not include the covered person's 1167
representative in any other context. 1168

(F) "Covered benefits" or "benefits" means those health 1169
care services to which a covered person is entitled under the 1170
terms of a health benefit plan. 1171

(G) "Emergency medical condition" has the same meaning as 1172
in section 1753.28 of the Revised Code. 1173

(H) "Emergency services" has the same meaning as in 1174
section 1753.28 of the Revised Code. 1175

(I) "Evidence-based standard" means the conscientious, 1176
explicit, and judicious use of the current best evidence, based 1177
on a systematic review of the relevant research, in making 1178
decisions about the care of individuals. 1179

(J) "Facility" means an institution providing health care 1180
services, or a health care setting, including hospitals and 1181
other licensed inpatient centers, ambulatory, surgical, 1182
treatment, skilled nursing, residential treatment, diagnostic, 1183
laboratory, and imaging centers, and rehabilitation and other 1184
therapeutic health settings. 1185

(K) "Final adverse benefit determination" means an adverse 1186
benefit determination that is upheld at the completion of a 1187
health plan issuer's internal appeals process. 1188

(L) "Health benefit plan" means a policy, contract, 1189
certificate, or agreement offered by a health plan issuer to 1190
provide, deliver, arrange for, pay for, or reimburse any of the 1191
costs of health care services, including benefit plans marketed 1192
in the individual or group market by all associations, whether 1193
bona fide or non-bona fide. "Health benefit plan" also means a 1194
limited benefit plan, except as follows. "Health benefit plan" 1195

does not mean any of the following types of coverage: a policy, 1196
contract, certificate, or agreement that covers only a specified 1197
accident, accident only, credit, dental, disability income, 1198
long-term care, hospital indemnity, supplemental coverage, as 1199
described in section 3923.37 of the Revised Code, specified 1200
disease, or vision care; coverage issued as a supplement to 1201
liability insurance; insurance arising out of workers' 1202
compensation or similar law; automobile medical payment 1203
insurance; or insurance under which benefits are payable with or 1204
without regard to fault and which is statutorily required to be 1205
contained in any liability insurance policy or equivalent self- 1206
insurance; a medicare supplement policy of insurance, as defined 1207
by the superintendent of insurance by rule, coverage under a 1208
plan through medicare, medicaid, or the federal employees 1209
benefit program; any coverage issued under Chapter 55 of Title 1210
10 of the United States Code and any coverage issued as a 1211
supplement to that coverage. 1212

(M) "Health care professional" means a physician, 1213
psychologist, nurse practitioner, or other health care 1214
practitioner licensed, accredited, or certified to perform 1215
health care services consistent with state law. 1216

(N) "Health care provider" or "provider" means a health 1217
care professional or facility. 1218

(O) "Health care services" means services for the 1219
diagnosis, prevention, treatment, cure, or relief of a health 1220
condition, illness, injury, or disease. 1221

(P) "Health plan issuer" means an entity subject to the 1222
insurance laws and rules of this state, or subject to the 1223
jurisdiction of the superintendent of insurance, that contracts, 1224
or offers to contract to provide, deliver, arrange for, pay for, 1225

or reimburse any of the costs of health care services under a 1226
health benefit plan, including a sickness and accident insurance 1227
company, a health insuring corporation, a fraternal benefit 1228
society, a self-funded multiple employer welfare arrangement, or 1229
a nonfederal, government health plan. "Health plan issuer" 1230
includes a third party administrator licensed under Chapter 1231
3959. of the Revised Code to the extent that the benefits that 1232
such an entity is contracted to administer under a health 1233
benefit plan are subject to the insurance laws and rules of this 1234
state or subject to the jurisdiction of the superintendent. 1235

(Q) "Health information" means information or data, 1236
whether oral or recorded in any form or medium, and personal 1237
facts or information about events or relationships that relates 1238
to all of the following: 1239

(1) The past, present, or future physical, mental, or 1240
behavioral health or condition of a covered person or a member 1241
of the covered person's family; 1242

(2) The provision of health care services or health- 1243
related benefits to a covered person; 1244

(3) Payment for the provision of health care services to 1245
or for a covered person. 1246

(R) "Independent review organization" means an entity that 1247
is accredited to conduct independent external reviews of adverse 1248
benefit determinations pursuant to section 3922.13 of the 1249
Revised Code. 1250

(S) "Medical or scientific evidence" means evidence found 1251
in any of the following sources: 1252

(1) Peer-reviewed scientific studies published in, or 1253
accepted for publication by, medical journals that meet 1254

nationally recognized requirements for scientific manuscripts 1255
and that submit most of their published articles for review by 1256
experts who are not part of the editorial staff; 1257

(2) Peer-reviewed medical literature, including literature 1258
relating to therapies reviewed and approved by a qualified 1259
institutional review board, biomedical compendia and other 1260
medical literature that meet the criteria of the national 1261
institutes of health's library of medicine for indexing in index 1262
medicus and elsevier science ltd. for indexing in excerpta 1263
medicus; 1264

(3) Medical journals recognized by the secretary of health 1265
and human services under section 1861(t)(2) of the federal 1266
social security act; 1267

(4) The following standard reference compendia: 1268

(a) The American hospital formulary service drug 1269
information; 1270

(b) Drug facts and comparisons; 1271

(c) The American dental association accepted dental 1272
therapeutics; 1273

(d) The United States pharmacopoeia drug information. 1274

(5) Findings, studies or research conducted by or under 1275
the auspices of a federal government agency or nationally 1276
recognized federal research institute, including any of the 1277
following: 1278

(a) The federal agency for health care research and 1279
quality; 1280

(b) The national institutes of health; 1281

(c) The national cancer institute;	1282
(d) The national academy of sciences;	1283
(e) The centers for medicare and medicaid services;	1284
(f) The federal food and drug administration;	1285
(g) Any national board recognized by the national	1286
institutes of health for the purpose of evaluating the medical	1287
value of health care services.	1288
(6) Any other medical or scientific evidence that is	1289
comparable.	1290
(T) "Person" has the same meaning as in section 3901.19 of	1291
the Revised Code.	1292
(U) "Protected health information" means health	1293
information related to the identity of an individual, or	1294
information that could reasonably be used to determine the	1295
identity of an individual.	1296
(V) "Rescind" means to retroactively cancel or discontinue	1297
coverage. "Rescind" does not include canceling or discontinuing	1298
coverage that only has a prospective effect or canceling or	1299
discontinuing coverage that is effective retroactively to the	1300
extent it is attributable to a failure to timely pay required	1301
premiums or contributions towards the cost of coverage.	1302
(W) "Retrospective review" means a review conducted after	1303
services have been provided to a covered person.	1304
(X) "Superintendent" means the superintendent of	1305
insurance.	1306
(Y) "Utilization review" has the same meaning as in	1307
section 1751.77 of the Revised Code.	1308

(Z) "Utilization review organization" has the same meaning
as in section 1751.77 of the Revised Code.

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

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

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

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

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

(a) The individual failed to pay premiums or contributions
in accordance with the terms of the policy or the insurer has

not received timely premium payments. 1338

(b) The individual performed an act or practice that 1339
constitutes fraud or made an intentional misrepresentation of 1340
material fact under the terms of the policy. 1341

(c) The insurer is ceasing to offer coverage in the 1342
individual market in accordance with division ~~(D)~~ (B) of this 1343
section and the applicable laws of this state. 1344

(d) If the insurer offers coverage in the market through a 1345
network plan, the individual no longer resides, lives, or works 1346
in the service area, or in an area for which the insurer is 1347
authorized to do business; provided, however, that such coverage 1348
is terminated uniformly without regard to any health status- 1349
related factor of covered individuals. 1350

(e) If the coverage is made available in the individual 1351
market only through one or more bona fide associations, the 1352
membership of the individual in the association, on the basis of 1353
which the coverage is provided, ceases; provided, however, that 1354
such coverage is terminated under division ~~(C) (2) (e)~~ (A) (2) (e) of 1355
this section uniformly without regard to any health status- 1356
related factor of covered individuals. 1357

(3) An insurer may cancel or decide not to renew the 1358
coverage of a dependent of an individual if the dependent has 1359
performed an act or practice that constitutes fraud or made an 1360
intentional misrepresentation of material fact under the terms 1361
of the coverage and if the cancellation or nonrenewal is not 1362
based, either directly or indirectly, on any health status- 1363
related factor in relation to the dependent. 1364

~~(D) (1)~~ (B) (1) If an insurer decides to discontinue offering 1365
a particular type of health insurance coverage offered in the 1366

individual market, coverage of such type may be discontinued by 1367
the insurer if the insurer does all of the following: 1368

(a) Provides notice to each individual provided coverage 1369
of this type in such market of the discontinuation at least 1370
ninety days prior to the date of the discontinuation of the 1371
coverage; 1372

(b) Offers to each individual provided coverage of this 1373
type in such market, the option to purchase any other individual 1374
health insurance coverage currently being offered by the insurer 1375
for individuals in that market; 1376

(c) In exercising the option to discontinue coverage of 1377
this type and in offering the option of coverage under division 1378
~~(D) (1) (b)~~ (B) (1) (b) of this section, acts uniformly without 1379
regard to any health status-related factor of covered 1380
individuals or of individuals who may become eligible for such 1381
coverage. 1382

(2) If an insurer elects to discontinue offering all 1383
health insurance coverage in the individual market in this 1384
state, health insurance coverage may be discontinued by the 1385
insurer only if both of the following apply: 1386

(a) The insurer provides notice to the department of 1387
insurance and to each individual of the discontinuation at least 1388
one hundred eighty days prior to the date of the expiration of 1389
the coverage. 1390

(b) All health insurance delivered or issued for delivery 1391
in this state in such market is discontinued and coverage under 1392
that health insurance in that market is not renewed. 1393

(3) In the event of a discontinuation under division ~~(D)~~ 1394
~~(2)~~ (B) (2) of this section in the individual market, the insurer 1395

shall not provide for the issuance of any health insurance 1396
coverage in the market and this state during the five-year 1397
period beginning on the date of the discontinuation of the last 1398
health insurance coverage not so renewed. 1399

~~(F)~~(C) Notwithstanding divisions ~~(C)~~(A) and ~~(D)~~(B) of this 1400
section, an insurer may, at the time of coverage renewal, modify 1401
the health insurance coverage for a policy form offered to 1402
individuals in the individual market if the modification is 1403
consistent with the law of this state and effective on a uniform 1404
basis among all individuals with that policy form. 1405

~~(F)~~(D) Such policies are subject to sections 2743 and 2747 1406
of the "Health Insurance Portability and Accountability Act of 1407
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 1408
and 300gg-47, as amended. 1409

~~(G)~~(E) Sections 3924.031 and 3924.032 of the Revised Code 1410
shall apply to sickness and accident insurance policies offered 1411
in the individual market in the same manner as they apply to 1412
health benefit plans offered in the small employer market. 1413

In accordance with 45 C.F.R. 148.102, divisions ~~(C)~~(A) to 1414
~~(G)~~(E) of this section also apply to all group sickness and 1415
accident insurance policies that are not sold in connection with 1416
an employment-related group health plan and that provide more 1417
than short-term, limited duration coverage. 1418

In applying divisions ~~(C)~~(A) to ~~(G)~~(E) of this section 1419
with respect to health insurance coverage that is made available 1420
by an insurer in the individual market to individuals only 1421
through one or more associations, the term "individual" includes 1422
the association of which the individual is a member. 1423

For purposes of this section, any policy issued pursuant 1424

to division (C) of section 3923.13 of the Revised Code in 1425
connection with a public or private college or university 1426
student health insurance program is considered to be issued to a 1427
bona fide association. 1428

As used in this section, "bona fide association" has the 1429
same meaning as in section 3924.03 of the Revised Code, and 1430
"health status-related factor" and "network plan" have the same 1431
meanings as in section 3924.031 of the Revised Code. 1432

This section does not apply to any policy that provides 1433
coverage for specific diseases or accidents only, or to any 1434
hospital indemnity, medicare supplement, long-term care, 1435
disability income, one-time-limited-duration policy that is less 1436
than twelve months, or other policy that offers only 1437
supplemental benefits. 1438

Sec. 3923.571. Except as otherwise provided in section 1439
2721 of the "Health Insurance Portability and Accountability Act 1440
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1441
300gg-21, as amended, the following conditions apply to all 1442
group policies of sickness and accident insurance that are sold 1443
in connection with an employment-related group health plan and 1444
that are not subject to section 3924.03 of the Revised Code: 1445

(A) Any such policy shall comply with the requirements of 1446
~~division (A) of section 3924.03 and section 3924.033 of the~~ 1447
Revised Code. 1448

(B) (1) Except as provided in section 2712(b) to (e) of the 1449
"Health Insurance Portability and Accountability Act of 1996," 1450
if an insurer offers coverage in the small or large group market 1451
in connection with a group policy, the insurer shall renew or 1452
continue in force such coverage at the option of the 1453

policyholder. 1454

(2) An insurer may cancel or decide not to renew the 1455
coverage of an employee or of a dependent of an employee if the 1456
employee or dependent, as applicable, has performed an act or 1457
practice that constitutes fraud or made an intentional 1458
misrepresentation of material fact under the terms of the 1459
coverage and if the cancellation or nonrenewal is not based, 1460
either directly or indirectly, on any health status-related 1461
factor in relation to the employee or dependent. 1462

As used in division (B)(2) of this section, "health 1463
status-related factor" has the same meaning as in section 1464
3924.031 of the Revised Code. 1465

(C)(1) No such policy, or insurer offering health 1466
insurance coverage in connection with such a policy, shall 1467
require any individual, as a condition of coverage or continued 1468
coverage under the policy, to pay a premium or contribution that 1469
is greater than the premium or contribution for a similarly 1470
situated individual covered under the policy on the basis of any 1471
health status-related factor in relation to the individual or to 1472
an individual covered under the policy as a dependent of the 1473
individual. 1474

(2) Nothing in division (C)(1) of this section shall be 1475
construed to restrict the amount that an employer may be charged 1476
for coverage under a group policy, or to prevent a group policy, 1477
and an insurer offering group health insurance coverage, from 1478
establishing premium discounts or rebates or modifying otherwise 1479
applicable copayments or deductibles in return for adherence to 1480
programs of health promotion and disease prevention. 1481

(D) Such policies shall provide for the special enrollment 1482

periods described in section 2701(f) of the "Health Insurance 1483
Portability and Accountability Act of 1996." 1484

(E) At least once in every twelve-month period, an insurer 1485
shall provide to all late enrollees, as defined in section 1486
3924.01 of the Revised Code, who are identified by the 1487
policyholder, the option to enroll in the group policy. The 1488
enrollment option shall be provided for a minimum period of 1489
thirty consecutive days. All delays of coverage imposed under 1490
the group policy, including any pre-existing condition exclusion 1491
period or service waiting period, shall begin on the date the 1492
insurer receives notice of the late enrollee's application or 1493
request for coverage, and shall run concurrently with each 1494
other. 1495

Sec. 3923.85. (A) As used in this section, "cost sharing" 1496
means the cost to an individual insured under an individual or 1497
group policy of sickness and accident insurance or a public 1498
employee benefit plan according to any coverage limit, 1499
copayment, coinsurance, deductible, or other out-of-pocket 1500
expense requirements imposed by the policy or plan. 1501

(B) Notwithstanding section 3901.71 of the Revised Code 1502
and subject to division (D) of this section, no individual or 1503
group policy of sickness and accident insurance that is 1504
delivered, issued for delivery, or renewed in this state and no 1505
public employee benefit plan that is established or modified in 1506
this state shall fail to comply with either of the following: 1507

(1) The policy or plan shall not provide coverage or 1508
impose cost sharing for a prescribed, orally administered cancer 1509
medication on a less favorable basis than the coverage it 1510
provides or cost sharing it imposes for intravenously 1511
administered or injected cancer medications. 1512

(2) The policy or plan shall not comply with division (B) 1513
(1) of this section by imposing an increase in cost sharing 1514
solely for orally administered, intravenously administered, or 1515
injected cancer medications. 1516

(C) Notwithstanding any provision of this section to the 1517
contrary, a policy or plan shall be deemed to be in compliance 1518
with this section if the cost sharing imposed under such a 1519
policy or plan for orally administered cancer treatments does 1520
not exceed one hundred dollars per prescription fill. The cost 1521
-sharing limit of one hundred dollars per prescription fill 1522
shall apply to a high deductible plan, as defined in 26 U.S.C. 1523
223, or a catastrophic plan, described in division (D) (2) of 1524
section 3902.57 of the Revised Code and as defined in 42 U.S.C. 1525
18022, only after the deductible has been met. 1526

(D) (1) The prohibitions in division (B) of this section do 1527
not preclude an individual or group policy of sickness and 1528
accident insurance or public employee benefit plan from 1529
requiring an insured or plan member to obtain prior 1530
authorization before orally administered cancer medication is 1531
dispensed to the insured or plan member. 1532

(2) Division (B) of this section does not apply to the 1533
offer or renewal of any individual or group policy of sickness 1534
and accident insurance that provides coverage for specific 1535
diseases or accidents only, or to any hospital indemnity, 1536
medicare supplement, disability income, or other policy that 1537
offers only supplemental benefits. 1538

(E) An insurer that offers any sickness and accident 1539
insurance or any public employee benefit plan that offers 1540
coverage for basic health care services is not required to 1541
comply with division (B) of this section if all of the following 1542

apply: 1543

(1) The insurer or plan submits documentation certified by 1544
an independent member of the American academy of actuaries to 1545
the superintendent of insurance showing that compliance with 1546
division (B)(1) of this section for a period of at least six 1547
months independently caused the insurer or plan's costs for 1548
claims and administrative expenses for the coverage of basic 1549
health care services to increase by more than one per cent per 1550
year. 1551

(2) The insurer or plan submits a signed letter from an 1552
independent member of the American academy of actuaries to the 1553
superintendent of insurance opining that the increase in costs 1554
described in division (E)(1) of this section could reasonably 1555
justify an increase of more than one per cent in the annual 1556
premiums or rates charged by the insurer or plan for the 1557
coverage of basic health care services. 1558

(3) (a) The superintendent of insurance makes the following 1559
determinations from the documentation and opinion submitted 1560
pursuant to divisions (E)(1) and (2) of this section: 1561

(i) Compliance with division (B)(1) of this section for a 1562
period of at least six months independently caused the insurer 1563
or plan's costs for claims and administrative expenses for the 1564
coverage of basic health care services to increase more than one 1565
per cent per year. 1566

(ii) The increase in costs reasonably justifies an 1567
increase of more than one per cent in the annual premiums or 1568
rates charged by the insurer or plan for the coverage of basic 1569
health care services. 1570

(b) Any determination made by the superintendent under 1571

division (E) (3) of this section is subject to Chapter 119. of 1572
the Revised Code. 1573

Sec. 3924.01. As used in sections 3924.01 to 3924.06 of 1574
the Revised Code: 1575

(A) "Actuarial certification" means a written statement 1576
prepared by a member of the American academy of actuaries, or by 1577
any other person acceptable to the superintendent of insurance, 1578
that states that, based upon the person's examination, a carrier 1579
offering health benefit plans to small employers is in 1580
compliance with sections 3924.01 to 3924.06 of the Revised Code. 1581
"Actuarial certification" shall include a review of the 1582
appropriate records of, and the actuarial assumptions and 1583
methods used by, the carrier relative to establishing premium 1584
rates for the health benefit plans. 1585

(B) "Base premium rate" means, as to any health benefit 1586
plan that is issued by a carrier and that covers at least two 1587
but no more than fifty employees of a small employer, the lowest 1588
premium rate for a new or existing business prescribed by the 1589
carrier for the same or similar coverage under a plan or 1590
arrangement covering any small employer with similar case 1591
characteristics. 1592

(C) "Carrier" means any sickness and accident insurance 1593
company or health insuring corporation authorized to issue 1594
health benefit plans in this state or a MEWA. A sickness and 1595
accident insurance company that owns or operates a health 1596
insuring corporation, either as a separate corporation or as a 1597
line of business, shall be considered as a separate carrier from 1598
that health insuring corporation for purposes of sections 1599
3924.01 to 3924.06 of the Revised Code. 1600

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

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

(F) "Eligible employee" means an employee who works a normal work week of thirty or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

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

insurance policy or equivalent self-insurance. 1631

(H) "Late enrollee" means an eligible employee or 1632
dependent who enrolls in a small employer's health benefit plan 1633
other than during the first period in which the employee or 1634
dependent is eligible to enroll under the plan or during a 1635
special enrollment period described in section 2701(f) of the 1636
"Health Insurance Portability and Accountability Act of 1996," 1637
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as 1638
amended. 1639

(I) "MEWA" means any "multiple employer welfare 1640
arrangement" as defined in section 3 of the "Federal Employee 1641
Retirement Income Security Act of 1974," 88 Stat. 832, 29 1642
U.S.C.A. 1001, as amended, except for any arrangement which is 1643
fully insured as defined in division (b) (6) (D) of section 514 of 1644
that act. 1645

(J) "Midpoint rate" means, for small employers with 1646
similar case characteristics and plan designs and as determined 1647
by the applicable carrier for a rating period, the arithmetic 1648
average of the applicable base premium rate and the 1649
corresponding highest premium rate. 1650

(K) ~~"Pre-existing conditions provision" means a policy-~~ 1651
~~provision that excludes or limits coverage for charges or~~ 1652
~~expenses incurred during a specified period following the~~ 1653
~~insured's enrollment date as to a condition for which medical~~ 1654
~~advice, diagnosis, care, or treatment was recommended or~~ 1655
~~received during a specified period immediately preceding the~~ 1656
~~enrollment date. Genetic information shall not be treated as~~ 1657
~~such a condition in the absence of a diagnosis of the condition~~ 1658
~~related to such information.~~ 1659

~~For purposes of this division, "enrollment date" means,~~ 1660
~~with respect to an individual covered under a group health~~ 1661
~~benefit plan, the date of enrollment of the individual in the~~ 1662
~~plan or, if earlier, the first day of the waiting period for~~ 1663
~~such enrollment.~~ 1664

~~(L)~~ "Service waiting period" means the period of time 1665
after employment begins before an employee is eligible to be 1666
covered for benefits under the terms of any applicable health 1667
benefit plan offered by the small employer. 1668

~~(M) (1)~~ (L) (1) "Small employer" means, in connection with a 1669
group health benefit plan and with respect to a calendar year 1670
and a plan year, an employer who employed an average of at least 1671
two but no more than fifty eligible employees on business days 1672
during the preceding calendar year and who employs at least two 1673
employees on the first day of the plan year. 1674

(2) For purposes of division ~~(M) (1)~~ (L) (1) of this section, 1675
all persons treated as a single employer under subsection (b), 1676
(c), (m), or (o) of section 414 of the "Internal Revenue Code of 1677
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be 1678
considered one employer. In the case of an employer that was not 1679
in existence throughout the preceding calendar year, the 1680
determination of whether the employer is a small or large 1681
employer shall be based on the average number of eligible 1682
employees that it is reasonably expected the employer will 1683
employ on business days in the current calendar year. Any 1684
reference in division ~~(M)~~ (L) of this section to an "employer" 1685
includes any predecessor of the employer. Except as otherwise 1686
specifically provided, provisions of sections 3924.01 to 3924.06 1687
of the Revised Code that apply to a small employer that has a 1688
health benefit plan shall continue to apply until the plan 1689

anniversary following the date the employer no longer meets the 1690
requirements of this division. 1691

Sec. 3924.02. (A) An individual or group health benefit 1692
plan is subject to sections 3924.01 to 3924.06 of the Revised 1693
Code if it provides health care benefits covering at least two 1694
but no more than fifty employees of a small employer, and if it 1695
meets either of the following conditions: 1696

(1) Any portion of the premium or benefits is paid by a 1697
small employer, or any covered individual is reimbursed, whether 1698
through wage adjustments or otherwise, by a small employer for 1699
any portion of the premium. 1700

(2) The health benefit plan is treated by the employer or 1701
any of the covered individuals as part of a plan or program for 1702
purposes of section 106 or 162 of the "Internal Revenue Code of 1703
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended. 1704

(B) Notwithstanding division (A) of this section, 1705
divisions ~~(D)~~ (C), ~~(E)~~ ~~(2)~~ (D) (2), ~~(F)~~ (E), and ~~(G)~~ (F) of section 1706
3924.03 of the Revised Code and section 3924.04 of the Revised 1707
Code do not apply to health benefit policies that are not sold 1708
to owners of small businesses as an employment benefit plan. 1709
Such policies shall clearly state that they are not being sold 1710
as an employment benefit plan and that the owner of the business 1711
is not responsible, either directly or indirectly, for paying 1712
the premium or benefits. 1713

(C) Every health benefit plan offered or delivered by a 1714
carrier, other than a health insuring corporation, to a small 1715
employer is subject to sections 3923.23, 3923.231, 3923.232, 1716
3923.233, and 3923.234 of the Revised Code and any other 1717
provision of the Revised Code that requires the reimbursement, 1718

utilization, or consideration of a specific category of a 1719
licensed or certified health care practitioner. 1720

(D) Except as expressly provided in sections 3924.01 to 1721
3924.06 of the Revised Code, no health benefit plan offered to a 1722
small employer is subject to any of the following: 1723

(1) Any law that would inhibit any carrier from 1724
contracting with providers or groups of providers with respect 1725
to health care services or benefits; 1726

(2) Any law that would impose any restriction on the 1727
ability to negotiate with providers regarding the level or 1728
method of reimbursing care or services provided under the health 1729
benefit plan; 1730

(3) Any law that would require any carrier to either 1731
include a specific provider or class of provider when 1732
contracting for health care services or benefits, or to exclude 1733
any class of provider that is generally authorized by statute to 1734
provide such care. 1735

Sec. 3924.03. Except as otherwise provided in section 2721 1736
of the "Health Insurance Portability and Accountability Act of 1737
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1738
300gg-21, as amended, health benefit plans covering small 1739
employers are subject to the following conditions, as 1740
applicable: 1741

(A) (1) ~~Pre-existing conditions provisions shall not~~ 1742
~~exclude or limit coverage for a period beyond twelve months, or~~ 1743
~~eighteen months in the case of a late enrollee, following the~~ 1744
~~individual's enrollment date and may only relate to a physical~~ 1745
~~or mental condition, regardless of the cause of the condition,~~ 1746
~~for which medical advice, diagnosis, care, or treatment was~~ 1747

~~recommended or received within the six months immediately~~ 1748
~~preceding the enrollment date.~~ 1749

~~Division (A) (1) of this section is subject to the~~ 1750
~~exceptions set forth in section 2701(d) of the "Health Insurance~~ 1751
~~Portability and Accountability Act of 1996."~~ 1752

~~(2) The period of any such pre-existing condition~~ 1753
~~exclusion shall be reduced by the aggregate of the periods of~~ 1754
~~creditable coverage, if any, applicable to the employee or~~ 1755
~~dependent as of the enrollment date.~~ 1756

~~(3) A period of creditable coverage shall not be counted,~~ 1757
~~with respect to enrollment of an individual under a group health~~ 1758
~~benefit plan, if, after that period and before the enrollment~~ 1759
~~date, there was a sixty-three-day period during all of which the~~ 1760
~~individual was not covered under any creditable coverage.~~ 1761
~~Subsections (c) (2) to (4) and (c) of section 2701 of the "Health~~ 1762
~~Insurance Portability and Accountability Act of 1996" apply with~~ 1763
~~respect to crediting previous coverage.~~ 1764

~~(4) As used in division (A) of this section:~~ 1765

~~(a) "Creditable coverage" has the same meaning as in~~ 1766
~~section 2701(c) (1) of the "Health Insurance Portability and~~ 1767
~~Accountability Act of 1996."~~ 1768

~~(b) "Enrollment date" means, with respect to an individual~~ 1769
~~covered under a group health benefit plan, the date of~~ 1770
~~enrollment of the individual in the plan or, if earlier, the~~ 1771
~~first day of the waiting period for such enrollment.~~ 1772

~~(B) (1) Except as provided in section 2712(b) to (e) of the~~ 1773
~~"Health Insurance Portability and Accountability Act of 1996,"~~ 1774
~~if a carrier offers coverage in the small employer market in~~ 1775
~~connection with a group health benefit plan, the carrier shall~~ 1776

renew or continue in force such coverage at the option of the 1777
plan sponsor of the plan. 1778

(2) A carrier may cancel or decide not to renew the 1779
coverage of any eligible employee or of a dependent of an 1780
eligible employee if the employee or dependent, as applicable, 1781
has performed an act or practice that constitutes fraud or made 1782
an intentional misrepresentation of material fact under the 1783
terms of the coverage and if the cancellation or nonrenewal is 1784
not based, either directly or indirectly, on any health status- 1785
related factor in relation to the employee or dependent. 1786

As used in division ~~(B)~~(A) (2) of this section, "health 1787
status-related factor" has the same meaning as in section 1788
3924.031 of the Revised Code. 1789

~~(C)~~(B) A carrier shall not exclude any eligible employee 1790
or dependent, who would otherwise be covered under a health 1791
benefit plan, on the basis of any actual or expected health 1792
condition of the employee or dependent. 1793

If, prior to November 24, 1995, a carrier excluded an 1794
eligible employee or dependent, other than a late enrollee, on 1795
the basis of an actual or expected health condition, the carrier 1796
shall, upon the initial renewal of the coverage on or after that 1797
date, extend coverage to the employee or dependent if all other 1798
eligibility requirements are met. 1799

~~(D)~~(C) No health benefit plan issued by a carrier shall 1800
limit or exclude, by use of a rider or amendment applicable to a 1801
specific individual, coverage by type of illness, treatment, 1802
medical condition, or accident, ~~except for pre-existing~~ 1803
~~conditions as permitted under division (A) of this section.~~ If a 1804
health benefit plan that is delivered or issued for delivery 1805

prior to April 14, 1993, contains such limitations or 1806
exclusions, by use of a rider or amendment applicable to a 1807
specific individual, the plan shall eliminate the use of such 1808
riders or amendments within eighteen months after April 14, 1809
1993. 1810

~~(E)~~ (D) (1) Except as provided in sections 3924.031 and 1811
3924.032 of the Revised Code, and subject to such rules as may 1812
be adopted by the superintendent of insurance in accordance with 1813
Chapter 119. of the Revised Code, a carrier shall offer and make 1814
available every health benefit plan that it is actively 1815
marketing to every small employer that applies to the carrier 1816
for such coverage. 1817

Division ~~(E)~~ (D) (1) of this section does not apply to a 1818
health benefit plan that a carrier makes available in the small 1819
employer market only through one or more bona fide associations. 1820

Division ~~(E)~~ (D) (1) of this section shall not be construed 1821
to preclude a carrier from establishing employer contribution 1822
rules or group participation rules for the offering of coverage 1823
in connection with a group health benefit plan in the small 1824
employer market, as allowed under the law of this state. As used 1825
in division ~~(E)~~ (D) (1) of this section, "employer contribution 1826
rule" means a requirement relating to the minimum level or 1827
amount of employer contribution toward the premium for 1828
enrollment of employees and dependents and "group participation 1829
rule" means a requirement relating to the minimum number of 1830
employees or dependents that must be enrolled in relation to a 1831
specified percentage or number of eligible individuals or 1832
employees of an employer. 1833

(2) Each health benefit plan, at the time of initial group 1834
enrollment, shall make coverage available to all the eligible 1835

employees of a small employer without a service waiting period. 1836
The decision of whether to impose a service waiting period shall 1837
be made by the small employer. Such waiting periods shall not be 1838
greater than ninety days. 1839

(3) Each health benefit plan shall provide for the special 1840
enrollment periods described in section 2701(f) of the "Health 1841
Insurance Portability and Accountability Act of 1996." 1842

(4) At least once in every twelve-month period, a carrier 1843
shall provide to all late enrollees who are identified by the 1844
small employer, the option to enroll in the health benefit plan. 1845
The enrollment option shall be provided for a minimum period of 1846
thirty consecutive days. All delays of coverage imposed under 1847
the health benefit plan, including any ~~pre-existing condition~~ 1848
~~exclusion period~~, affiliation period, or service waiting period, 1849
shall begin on the date the carrier receives notice of the late 1850
enrollee's application or request for coverage, and shall run 1851
concurrently with each other. 1852

~~(F)~~ (E) The benefit structure of any health benefit plan 1853
may, at the time of coverage renewal, be changed by the carrier 1854
to make it consistent with the benefit structure contained in 1855
health benefit plans being marketed to new small employer 1856
groups. If the health benefit plan is available in the small 1857
employer market other than only through one or more bona fide 1858
associations, the modification must be consistent with the law 1859
of this state and effective on a uniform basis among small 1860
employer group plans. 1861

~~(G)~~ (F) A carrier may obtain any facts and information 1862
necessary to apply this section, or supply those facts and 1863
information to any other third-party payer, without the consent 1864
of the beneficiary. Each person claiming benefits under a health 1865

benefit plan shall provide any facts and information necessary 1866
to apply this section. 1867

For purposes of this section, "bona fide association" 1868
means an association that has been actively in existence for at 1869
least five years; has been formed and maintained in good faith 1870
for purposes other than obtaining insurance; does not condition 1871
membership in the association on any health status-related 1872
factor, as defined in section 3924.031 of the Revised Code, 1873
relating to an individual, including an employee or dependent; 1874
makes health insurance coverage offered through the association 1875
available to all members regardless of any health status-related 1876
factor, as defined in section 3924.031 of the Revised Code, 1877
relating to such members or to individuals eligible for coverage 1878
through a member; does not make health insurance coverage 1879
offered through the association available other than in 1880
connection with a member of the association; and meets any other 1881
requirement imposed by the superintendent. To maintain its 1882
status as a "bona fide association," each association shall 1883
annually certify to the superintendent that it meets the 1884
requirements of this paragraph. 1885

Sec. 3924.033. (A) Each carrier, in connection with the 1886
offering of a health benefit plan to a small employer, shall 1887
disclose to the employer, as part of its solicitation and sales 1888
materials, the following information: 1889

(1) The provisions of the plan concerning the carrier's 1890
right to change premium rates and the factors that may affect 1891
changes in premium rates; 1892

(2) The provisions of the plan relating to renewability of 1893
coverage; 1894

(3) ~~The provisions of the plan relating to any pre-~~ 1895
~~existing condition exclusion;~~ 1896

~~(4)~~ The benefits and premiums available under all health 1897
benefit plans for which the employer is qualified. 1898

(B) The information described in division (A) of this 1899
section shall be provided in a manner determined to be 1900
understandable by the average small employer, and in a manner 1901
sufficient to reasonably inform a small employer regarding the 1902
employer's rights and obligations under the health benefit plan. 1903

(C) Nothing in this section requires a carrier to disclose 1904
any information that is by law proprietary and trade secret 1905
information. 1906

Sec. 3924.51. (A) As used in this section: 1907

(1) "Child" means, in connection with any adoption or 1908
placement for adoption of the child, an individual who has not 1909
attained age eighteen as of the date of the adoption or 1910
placement for adoption. 1911

(2) "Health insurer" has the same meaning as in section 1912
3924.41 of the Revised Code. 1913

(3) "Placement for adoption" means the assumption and 1914
retention by a person of a legal obligation for total or partial 1915
support of a child in anticipation of the adoption of the child. 1916
The child's placement with a person terminates upon the 1917
termination of that legal obligation. 1918

(B) If an individual or group health plan of a health 1919
insurer makes coverage available for dependent children of 1920
participants or beneficiaries, the plan shall provide benefits 1921
to dependent children placed with participants or beneficiaries 1922

for adoption under the same terms and conditions as apply to the 1923
natural, dependent children of the participants and 1924
beneficiaries, irrespective of whether the adoption has become 1925
final. 1926

~~(C) A health plan described in division (B) of this 1927
section shall not restrict coverage under the plan of any 1928
dependent child adopted by a participant or beneficiary, or 1929
placed with a participant or beneficiary for adoption, solely on 1930
the basis of a pre-existing condition of the child at the time 1931
that the child would otherwise become eligible for coverage 1932
under the plan, if the adoption or placement for adoption occurs 1933
while the participant or beneficiary is eligible for coverage 1934
under the plan. 1935~~

Sec. 4125.041. A shared employee under a professional 1936
employer organization agreement shall not, solely as a result of 1937
being a shared employee, be considered an employee of the 1938
professional employer organization for purposes of general 1939
liability insurance, fidelity bonds, surety bonds, employer 1940
liability not otherwise covered by Chapters 4121. and 4123. of 1941
the Revised Code, or liquor liability insurance carried by the 1942
professional employer organization, unless the professional 1943
employer organization agreement and applicable prearranged 1944
employment contract, insurance contract, or bond specifically 1945
states otherwise. 1946

A shared employee shall be considered an employee of the 1947
professional employer organization for purposes of determining 1948
whether a professional employer organization who sponsors a 1949
group health benefit plan is a small employer under division ~~(M)~~ 1950
~~(1)~~ (L) (1) of section 3924.01 of the Revised Code. A fully 1951
insured health benefit plan sponsored by a professional employer 1952

organization is not subject to sections 3924.01 to 3924.06 of 1953
the Revised Code if the professional employer organization is 1954
not a small employer for purposes of those sections. 1955

Section 2. That existing sections 1731.04, 1751.01, 1956
1751.06, 1751.12, 1751.18, 1751.58, 1751.69, 3902.50, 3922.01, 1957
3923.57, 3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 1958
3924.51, and 4125.041 of the Revised Code are hereby repealed. 1959

Section 3. This act shall apply to health benefit plans, 1960
as defined in section 3922.01 of the Revised Code, delivered, 1961
issued for delivery, modified, or renewed on or after the 1962
effective date of this act. 1963

Section 4. This act shall be known as the Fair Access to 1964
Medical Insurance for Local Youth and Families (FAMILY) Act. 1965

Section 5. Section 1751.12 of the Revised Code is 1966
presented in this act as a composite of the section as amended 1967
by both H.B. 3 and H.B. 59 of the 130th General Assembly. The 1968
General Assembly, applying the principle stated in division (B) 1969
of section 1.52 of the Revised Code that amendments are to be 1970
harmonized if reasonably capable of simultaneous operation, 1971
finds that the composite is the resulting version of the section 1972
in effect prior to the effective date of the section as 1973
presented in this act. 1974