

As Introduced

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H. B. No. 888

Representatives White, E., Bryant Bailey

Cosponsors: Representatives McNally, Piccolantonio

To amend section 1751.01 and to enact sections 1
3902.65 and 5164.11 of the Revised Code 2
concerning insurance and Medicaid coverage for 3
specified infertility services. 4

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

Section 1. That section 1751.01 be amended and sections 5
3902.65 and 5164.11 of the Revised Code be enacted to read as 6
follows: 7

Sec. 1751.01. As used in this chapter: 8

(A) (1) "Basic health care services" means the following 9
services when medically necessary: 10

(a) Physician's services, except when such services are 11
supplemental under division (B) of this section; 12

(b) Inpatient hospital services; 13

(c) Outpatient medical services; 14

(d) Emergency health services; 15

(e) Urgent care services; 16

(f) Diagnostic laboratory services and diagnostic and 17

therapeutic radiologic services;	18
(g) Diagnostic and treatment services, other than	19
prescription drug services, for biologically based mental	20
illnesses;	21
(h) Preventive health care services, including, but not	22
limited to, voluntary family planning services, infertility	23
services, periodic physical examinations, prenatal obstetrical	24
care, and well-child care;	25
(i) Routine patient care for patients enrolled in an	26
eligible cancer clinical trial pursuant to section 3923.80 of	27
the Revised Code.	28
"Basic health care services" does not include experimental	29
procedures.	30
Except as provided by divisions (A) (2) and (3) of this	31
section in connection with the offering of coverage for	32
diagnostic and treatment services for biologically based mental	33
illnesses, a health insuring corporation shall not offer	34
coverage for a health care service, defined as a basic health	35
care service by this division, unless it offers coverage for all	36
listed basic health care services. However, this requirement	37
does not apply to the coverage of beneficiaries enrolled in	38
medicare pursuant to a medicare contract, or to the coverage of	39
beneficiaries enrolled in the federal employee health benefits	40
program pursuant to 5 U.S.C.A. 8905, or to the coverage of	41
medicaid recipients, or to the coverage of beneficiaries under	42
any federal health care program regulated by a federal	43
regulatory body, or to the coverage of beneficiaries under any	44
contract covering officers or employees of the state that has	45
been entered into by the department of administrative services.	46

(2) A health insuring corporation may offer coverage for 47
diagnostic and treatment services for biologically based mental 48
illnesses without offering coverage for all other basic health 49
care services. A health insuring corporation may offer coverage 50
for diagnostic and treatment services for biologically based 51
mental illnesses alone or in combination with one or more 52
supplemental health care services. However, a health insuring 53
corporation that offers coverage for any other basic health care 54
service shall offer coverage for diagnostic and treatment 55
services for biologically based mental illnesses in combination 56
with the offer of coverage for all other listed basic health 57
care services. 58

(3) A health insuring corporation that offers coverage for 59
basic health care services is not required to offer coverage for 60
diagnostic and treatment services for biologically based mental 61
illnesses in combination with the offer of coverage for all 62
other listed basic health care services if all of the following 63
apply: 64

(a) The health insuring corporation submits documentation 65
certified by an independent member of the American academy of 66
actuaries to the superintendent of insurance showing that 67
incurred claims for diagnostic and treatment services for 68
biologically based mental illnesses for a period of at least six 69
months independently caused the health insuring corporation's 70
costs for claims and administrative expenses for the coverage of 71
basic health care services to increase by more than one per cent 72
per year. 73

(b) The health insuring corporation submits a signed 74
letter from an independent member of the American academy of 75
actuaries to the superintendent of insurance opining that the 76

increase in costs described in division (A) (3) (a) of this 77
section could reasonably justify an increase of more than one 78
per cent in the annual premiums or rates charged by the health 79
insuring corporation for the coverage of basic health care 80
services. 81

(c) The superintendent of insurance makes the following 82
determinations from the documentation and opinion submitted 83
pursuant to divisions (A) (3) (a) and (b) of this section: 84

(i) Incurred claims for diagnostic and treatment services 85
for biologically based mental illnesses for a period of at least 86
six months independently caused the health insuring 87
corporation's costs for claims and administrative expenses for 88
the coverage of basic health care services to increase by more 89
than one per cent per year. 90

(ii) The increase in costs reasonably justifies an 91
increase of more than one per cent in the annual premiums or 92
rates charged by the health insuring corporation for the 93
coverage of basic health care services. 94

Any determination made by the superintendent under this 95
division is subject to Chapter 119. of the Revised Code. 96

(4) To the extent permitted under federal law, a health 97
insuring corporation that offers coverage for basic health care 98
services shall cover, as infertility services, diagnostic and 99
exploratory procedures to determine infertility and surgical 100
procedures to correct a medically diagnosed disease or condition 101
of reproductive organs, including endometriosis, collapsed or 102
clogged fallopian tubes, and testicular failure. 103

(B) (1) "Supplemental health care services" means any 104
health care services other than basic health care services that 105

a health insuring corporation may offer, alone or in combination	106
with either basic health care services or other supplemental	107
health care services, and includes:	108
(a) Services of facilities for intermediate or long-term	109
care, or both;	110
(b) Dental care services;	111
(c) Vision care and optometric services including lenses	112
and frames;	113
(d) Podiatric care or foot care services;	114
(e) Mental health services, excluding diagnostic and	115
treatment services for biologically based mental illnesses;	116
(f) Short-term outpatient evaluative and crisis-	117
intervention mental health services;	118
(g) Medical or psychological treatment and referral	119
services for alcohol and drug abuse or addiction;	120
(h) Home health services;	121
(i) Prescription drug services;	122
(j) Nursing services;	123
(k) Services of a dietitian licensed under Chapter 4759.	124
of the Revised Code;	125
(l) Physical therapy services;	126
(m) Chiropractic services;	127
(n) Any other category of services approved by the	128
superintendent of insurance.	129
(2) If a health insuring corporation offers prescription	130

drug services under this division, the coverage shall include 131
prescription drug services for the treatment of biologically 132
based mental illnesses on the same terms and conditions as other 133
physical diseases and disorders. 134

(C) "Specialty health care services" means one of the 135
supplemental health care services listed in division (B) of this 136
section, when provided by a health insuring corporation on an 137
outpatient-only basis and not in combination with other 138
supplemental health care services. 139

(D) "Biologically based mental illnesses" means 140
schizophrenia, schizoaffective disorder, major depressive 141
disorder, bipolar disorder, paranoia and other psychotic 142
disorders, obsessive-compulsive disorder, and panic disorder, as 143
these terms are defined in the most recent edition of the 144
diagnostic and statistical manual of mental disorders published 145
by the American psychiatric association. 146

(E) "Closed panel plan" means a health care plan that 147
requires enrollees to use participating providers. 148

(F) "Compensation" means remuneration for the provision of 149
health care services, determined on other than a fee-for-service 150
or discounted-fee-for-service basis. 151

(G) "Contractual periodic prepayment" means the formula 152
for determining the premium rate for all subscribers of a health 153
insuring corporation. 154

(H) "Corporation" means a corporation formed under Chapter 155
1701. or 1702. of the Revised Code or the similar laws of 156
another state. 157

(I) "Emergency health services" means those health care 158
services that must be available on a seven-days-per-week, 159

twenty-four-hours-per-day basis in order to prevent jeopardy to 160
an enrollee's health status that would occur if such services 161
were not received as soon as possible, and includes, where 162
appropriate, provisions for transportation and indemnity 163
payments or service agreements for out-of-area coverage. 164

(J) "Enrollee" means any natural person who is entitled to 165
receive health care benefits provided by a health insuring 166
corporation. 167

(K) "Evidence of coverage" means any certificate, 168
agreement, policy, or contract issued to a subscriber that sets 169
out the coverage and other rights to which such person is 170
entitled under a health care plan. 171

(L) "Health care facility" means any facility, except a 172
health care practitioner's office, that provides preventive, 173
diagnostic, therapeutic, acute convalescent, rehabilitation, 174
mental health, intellectual disability, intermediate care, or 175
skilled nursing services. 176

(M) "Health care services" means basic, supplemental, and 177
specialty health care services. 178

(N) "Health delivery network" means any group of providers 179
or health care facilities, or both, or any representative 180
thereof, that have entered into an agreement to offer health 181
care services in a panel rather than on an individual basis. 182

(O) "Health insuring corporation" means a corporation, as 183
defined in division (H) of this section, that, pursuant to a 184
policy, contract, certificate, or agreement, pays for, 185
reimburses, or provides, delivers, arranges for, or otherwise 186
makes available, basic health care services, supplemental health 187
care services, or specialty health care services, or a 188

combination of basic health care services and either 189
supplemental health care services or specialty health care 190
services, through either an open panel plan or a closed panel 191
plan. 192

"Health insuring corporation" does not include a limited 193
liability company formed pursuant to Chapter 1705. or 1706. of 194
the Revised Code, an insurer licensed under Title XXXIX of the 195
Revised Code if that insurer offers only open panel plans under 196
which all providers and health care facilities participating 197
receive their compensation directly from the insurer, a 198
corporation formed by or on behalf of a political subdivision or 199
a department, office, or institution of the state, or a public 200
entity formed by or on behalf of a board of county 201
commissioners, a county board of developmental disabilities, an 202
alcohol and drug addiction services board, a board of alcohol, 203
drug addiction, and mental health services, or a community 204
mental health board, as those terms are used in Chapters 340. 205
and 5126. of the Revised Code. Except as provided by division 206
(D) of section 1751.02 of the Revised Code, or as otherwise 207
provided by law, no board, commission, agency, or other entity 208
under the control of a political subdivision may accept 209
insurance risk in providing for health care services. However, 210
nothing in this division shall be construed as prohibiting such 211
entities from purchasing the services of a health insuring 212
corporation or a third-party administrator licensed under 213
Chapter 3959. of the Revised Code. 214

(P) "Intermediary organization" means a health delivery 215
network or other entity that contracts with licensed health 216
insuring corporations or self-insured employers, or both, to 217
provide health care services, and that enters into contractual 218
arrangements with other entities for the provision of health 219

care services for the purpose of fulfilling the terms of its 220
contracts with the health insuring corporations and self-insured 221
employers. 222

(Q) "Intermediate care" means residential care above the 223
level of room and board for patients who require personal 224
assistance and health-related services, but who do not require 225
skilled nursing care. 226

(R) "Medical record" means the personal information that 227
relates to an individual's physical or mental condition, medical 228
history, or medical treatment. 229

(S) (1) "Open panel plan" means a health care plan that 230
provides incentives for enrollees to use participating providers 231
and that also allows enrollees to use providers that are not 232
participating providers. 233

(2) No health insuring corporation may offer an open panel 234
plan, unless the health insuring corporation is also licensed as 235
an insurer under Title XXXIX of the Revised Code, the health 236
insuring corporation, on June 4, 1997, holds a certificate of 237
authority or license to operate under Chapter 1736. or 1740. of 238
the Revised Code, or an insurer licensed under Title XXXIX of 239
the Revised Code is responsible for the out-of-network risk as 240
evidenced by both an evidence of coverage filing under section 241
1751.11 of the Revised Code and a policy and certificate filing 242
under section 3923.02 of the Revised Code. 243

(T) "Osteopathic hospital" means a hospital registered 244
under section 3701.07 of the Revised Code that advocates 245
osteopathic principles and the practice and perpetuation of 246
osteopathic medicine by doing any of the following: 247

(1) Maintaining a department or service of osteopathic 248

medicine or a committee on the utilization of osteopathic	249
principles and methods, under the supervision of an osteopathic	250
physician;	251
(2) Maintaining an active medical staff, the majority of	252
which is comprised of osteopathic physicians;	253
(3) Maintaining a medical staff executive committee that	254
has osteopathic physicians as a majority of its members.	255
(U) "Panel" means a group of providers or health care	256
facilities that have joined together to deliver health care	257
services through a contractual arrangement with a health	258
insuring corporation, employer group, or other payor.	259
(V) "Person" has the same meaning as in section 1.59 of	260
the Revised Code, and, unless the context otherwise requires,	261
includes any insurance company holding a certificate of	262
authority under Title XXXIX of the Revised Code, any subsidiary	263
and affiliate of an insurance company, and any government	264
agency.	265
(W) "Premium rate" means any set fee regularly paid by a	266
subscriber to a health insuring corporation. A "premium rate"	267
does not include a one-time membership fee, an annual	268
administrative fee, or a nominal access fee, paid to a managed	269
health care system under which the recipient of health care	270
services remains solely responsible for any charges accessed for	271
those services by the provider or health care facility.	272
(X) "Primary care provider" means a provider that is	273
designated by a health insuring corporation to supervise,	274
coordinate, or provide initial care or continuing care to an	275
enrollee, and that may be required by the health insuring	276
corporation to initiate a referral for specialty care and to	277

maintain supervision of the health care services rendered to the 278
enrollee. 279

(Y) "Provider" means any natural person or partnership of 280
natural persons who are licensed, certified, accredited, or 281
otherwise authorized in this state to furnish health care 282
services, or any professional association organized under 283
Chapter 1785. of the Revised Code, provided that nothing in this 284
chapter or other provisions of law shall be construed to 285
preclude a health insuring corporation, health care 286
practitioner, or organized health care group associated with a 287
health insuring corporation from employing certified nurse 288
practitioners, certified nurse anesthetists, clinical nurse 289
specialists, certified nurse-midwives, pharmacists, dietitians, 290
physician assistants, dental assistants, dental hygienists, 291
optometric technicians, or other allied health personnel who are 292
licensed, certified, accredited, or otherwise authorized in this 293
state to furnish health care services. 294

(Z) "Provider sponsored organization" means a corporation, 295
as defined in division (H) of this section, that is at least 296
eighty per cent owned or controlled by one or more hospitals, as 297
defined in section 3727.01 of the Revised Code, or one or more 298
physicians licensed to practice medicine or surgery or 299
osteopathic medicine and surgery under Chapter 4731. of the 300
Revised Code, or any combination of such physicians and 301
hospitals. Such control is presumed to exist if at least eighty 302
per cent of the voting rights or governance rights of a provider 303
sponsored organization are directly or indirectly owned, 304
controlled, or otherwise held by any combination of the 305
physicians and hospitals described in this division. 306

(AA) "Solicitation document" means the written materials 307

provided to prospective subscribers or enrollees, or both, and 308
used for advertising and marketing to induce enrollment in the 309
health care plans of a health insuring corporation. 310

(BB) "Subscriber" means a person who is responsible for 311
making payments to a health insuring corporation for 312
participation in a health care plan, or an enrollee whose 313
employment or other status is the basis of eligibility for 314
enrollment in a health insuring corporation. 315

(CC) "Urgent care services" means those health care 316
services that are appropriately provided for an unforeseen 317
condition of a kind that usually requires medical attention 318
without delay but that does not pose a threat to the life, limb, 319
or permanent health of the injured or ill person, and may 320
include such health care services provided out of the health 321
insuring corporation's approved service area pursuant to 322
indemnity payments or service agreements. 323

Sec. 3902.65. (A) As used in this section: 324

(1) "Assisted reproductive technology" means any 325
fertility-related treatment in which eggs are surgically removed 326
from a woman's ovaries, combined with sperm in a laboratory, and 327
transferred back to that woman or a gestational carrier, 328
including in vitro fertilization, gamete intrafallopian 329
transfer, or zygote intrafallopian transfer. "Assisted 330
reproductive technology" does not include any treatment in which 331
only sperm are handled, such as intrauterine insemination or 332
procedures in which a woman takes medication to stimulate egg 333
production without planning to have the eggs surgically 334
retrieved. 335

(2) "Treatment for conditions that impact fertility" means 336

<u>any treatment or procedure that seeks to remedy one or more</u>	337
<u>medical conditions or diagnoses that affect the male or female</u>	338
<u>reproductive system and result in the inability to conceive</u>	339
<u>through sexual intercourse, with the goal of achieving a</u>	340
<u>successful pregnancy without the use of assisted reproductive</u>	341
<u>technology. "Treatment for conditions that impact fertility"</u>	342
<u>includes medications that stimulate ovulation, intrauterine</u>	343
<u>insemination, laparoscopic surgery, and treatment for any of the</u>	344
<u>following:</u>	345
<u>(a) Conditions that result in a failure to ovulate;</u>	346
<u>(b) Issues in the menstrual cycle;</u>	347
<u>(c) Structural problems of the male or female reproductive</u>	348
<u>system;</u>	349
<u>(d) Infections that impact fertility;</u>	350
<u>(e) Conditions that result in the failure of an egg to</u>	351
<u>mature properly;</u>	352
<u>(f) Implantation failure;</u>	353
<u>(g) Endometriosis;</u>	354
<u>(h) Polycystic ovary syndrome;</u>	355
<u>(i) Primary ovary insufficiency;</u>	356
<u>(j) Uterine fibroids;</u>	357
<u>(k) Autoimmune disorders that impact fertility;</u>	358
<u>(l) Sperm disorders.</u>	359
<u>(B) Notwithstanding section 3901.71 of the Revised Code,</u>	360
<u>on and after the effective date of this section, a health</u>	361
<u>benefit plan that offers coverage of basic health care services</u>	362

shall cover assisted reproductive technology and treatment for 363
conditions that impact fertility to the same extent that the 364
plan covers other medical procedures and treatments for female 365
reproductive care or male infertility treatments and procedures. 366
A cost-sharing requirement for assisted reproductive technology 367
and treatment for conditions that impact fertility shall not 368
exceed the cost-sharing requirement imposed by the plan for 369
other medical procedures and treatments for female reproductive 370
care or male infertility treatments and procedures. 371

Sec. 5164.11. (A) As used in this section, "assisted 372
reproductive technology" and "treatment for conditions that 373
impact fertility" have the same meanings as in section 3902.65 374
of the Revised Code. 375

(B) The medicaid program shall cover assisted reproductive 376
technology and treatment for conditions that impact fertility to 377
the same extent that the program covers other medical procedures 378
and treatments for female reproductive care or male infertility 379
treatments and procedures. 380

Section 2. That existing section 1751.01 of the Revised 381
Code is hereby repealed. 382