As Introduced

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H. B. No. 891

Representative Hall, D.

Cosponsors: Representatives Piccolantonio, Brennan, White, E., Upchurch

To amend sections 3901.22 and 3922.07 and to enact sections 3901.216, 3901.97, and 3922.171 of the Revised Code to establish a medical claims consumer assistance program, to prohibit health insurers from improperly denying health claims, and to name this act the Fair Health Claims Act.

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

Section 1. That sections 3901.22 and 3922.07 be amended and sections 3901.216, 3901.97, and 3922.171 of the Revised Code be enacted to read as follows:

Sec. 3901.216. (A) As used in this section, "covered person," "health benefit plan," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(B) A health plan issuer shall not wrongfully deny, reduce, or terminate a requested health care service or payment that is covered under a health benefit plan.

(C) A violation of this section is subject to the procedures and penalties set forth in section 3901.22 of the Revised Code, except as provided in this division. To the extent that any of the provisions of this division conflict with

section 3901.22 of the Revised Code, the provisions of this division apply.

(1) If the superintendent of insurance finds that a health plan issuer has violated this section, the superintendent may request the attorney general to commence and prosecute an action or proceeding in the name of the state against the health plan issuer. In addition to the penalties imposed by section 3901.22 of the Revised Code, the court may do all of the following in such an action:

(a) Order the health plan issuer to pay to the covered person double the amount of the wrongful denial, reduction, or termination of a requested health care service or payment, plus all expenses reasonably incurred by the covered person to retain attorneys, actuaries, accountants, and other experts to assist in the matter;

(b) Impose damages to be paid by the health plan issuer to the covered person, in an amount to be determined by the court;

(c) Impose a civil penalty of not more than twenty-five thousand dollars for each violation.

(2) The court may impose additional penalties against a health plan issuer for repeated violations of this section.

(3) When imposing penalties under division (C)(1) or (2) of this section, the court shall consider the factors listed in division (E) of this section.

(D) Beginning one year after the effective date of this section and annually thereafter, the superintendent shall increase any penalty amounts specified in division (C) of this section by the higher of the average rate of change in health insurance premium rates in the individual and small group

marketplaces in this state or the current penalty amounts increased by the rate of inflation for health insurance, as indicated in the consumer price index for all urban consumers as published by the United States bureau of labor statistics.

(E) In determining penalties under under this section or section 3901.22 of the Revised Code, the superintendent or court shall consider all of the following factors:

(1) The nature, scope, and gravity of the violation;

(2) The severity of the harm to the covered person, including loss of life or health, emotional distress, and financial harm;

(3) The nature and extent to which the health plan issuer cooperates with the department of insurance during an investigation of the violation;

(4) The nature and extent to which the health plan issuer aggravated or mitigated any injury or damage caused by the violation;

(5) The nature and extent to which the health plan issuer has taken corrective action to ensure such a violation will not recur;

(6) Evidence of the good or bad faith, intent, or willfulness of the health plan issuer;

(7) The health plan issuer's history of violations of this section and whether the alleged violation is an isolated incident;

(8) The financial status of the health plan issuer and its affiliates, including its reserves, financial solvency, excess revenues, or other financial factors;

(9) The cost of the health care service in question, including whether a penalty is commensurate with or exceeds the cost of the service and the cost based on the number of covered persons affected;

(10) The number of covered persons affected;

(11) The frequency of the violation, based on the number of days of the violation or the estimated number of incidents;

(12) The severity of the potential harm resulting from the violation, including loss of life or health, emotional distress, or financial harm to covered persons;

(13) The amount of a financial penalty necessary to deter similar violations in the future.

Sec. 3901.22. Except as provided in section 3901.216 of the Revised Code, all of the following apply to violations of section 3901.20 of the Revised Code:

(A) The superintendent of insurance may conduct hearings to determine whether violations of section 3901.20 of the Revised Code have occurred. Any person aggrieved with respect to any act that the person believes to be an unfair or deceptive act or practice in the business of insurance, as defined in section 3901.21 or 3901.211 of the Revised Code or in any rule of the superintendent, may make written application to the superintendent for a hearing to determine if there has been a violation of section 3901.20 of the Revised Code. The application shall specify the grounds to be relied upon by the applicant. If the superintendent finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds are established, and that such grounds otherwise justify holding such a hearing, the superintendent

shall hold a hearing to determine whether the act specified in the application is a violation of section 3901.20 of the Revised Code. Notice of any hearing held under the authority of this section, the conduct of the hearing, the orders issued pursuant to it, the review of the orders and all other matters relating to the holding of the hearing shall be governed by Chapter 119. of the Revised Code.

(B) Upon good cause shown, the superintendent shall permit any person to intervene, appear, and be heard at the hearing, either in person or by counsel.

(C) The superintendent shall send a copy of the order to those persons intervening in the hearing.

(D) If the superintendent, by written order, finds that any person has violated section 3901.20 of the Revised Code, the superintendent shall issue an order requiring that person to cease and desist from engaging in the violation. In addition, the superintendent may impose any or all of the following administrative remedies upon the person:

(1) The superintendent may suspend or revoke the person's license to engage in the business of insurance;

(2) The superintendent may order that an insurance company or insurance agency not employ the person or permit the person to serve as a director, consultant, or in any other capacity for such time as the superintendent determines would serve the public interest. No application for termination of such an order for an indefinite time shall be filed within two years of its effective date.

(3) The superintendent may order the person to return any payments received by the person as a result of the violation;

(4) If the superintendent issues an order pursuant to division (D)(3) of this section, the superintendent shall order the person to pay statutory interest on such payments.

If the superintendent does not issue orders pursuant to divisions (D)(3) and (4) of this section, the superintendent shall expressly state in the cease-and-desist order the reasons for not issuing such orders.

(5) The superintendent may order the person to pay to the state treasury for credit to the department's operating fund an amount, not in excess of one hundred thousand dollars, equal to one-half of the expenses reasonably incurred by the superintendent to retain attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff to assist directly in the conduct of any investigations and hearings conducted with respect to violations committed by the person.

(E) If the superintendent has reasonable cause to believe that an order issued pursuant to division (D) of this section has been violated in whole or in part, the superintendent may, unless such order is stayed by a court of competent jurisdiction, request the attorney general to commence and prosecute any appropriate action or proceeding in the name of the state against the person.

Such action may include, but need not be limited to, the commencement of a class action under Civil Rule 23 on behalf of policyholders, subscribers, applicants for policies or contracts, or other insurance consumers for damages caused by or unjust enrichment received as a result of the violation.

(F) In addition to any penalties imposed pursuant to this

chapter, the court may, in an action brought pursuant to division (E) of this section, impose any of the following:

(1) For each act or practice found to be in violation of section 3901.20 of the Revised Code, a civil penalty of not more than three thousand five hundred dollars for each violation but not to exceed an aggregate penalty of thirty-five thousand dollars in any six-month period, provided that a series of similar acts or practices prohibited by section 3901.20 of the Revised Code and committed by the same person but not in separate insurance sales transactions shall be considered a single violation;

(2) For each violation of a cease and desist order issued by the superintendent pursuant to this section, a civil penalty of not more than ten thousand dollars;

(3) In addition to any other appropriate relief, the court may order any or all of the remedies specified in division (D) of this section.

(G) The superintendent, under a settlement agreement to which a person has consented in writing for the purpose of assuring the person's correction of a series of offenses and future compliance with the laws of this state relating to the business of insurance, may impose a single penalty in whatever amount the parties determine to be justified under the circumstances.

(H) A court of common pleas, in a civil action commenced by the attorney general on behalf of the superintendent under Civil Rule 65, may grant a temporary restraining order, preliminary injunction, or permanent injunction to restrain or prevent a violation or threatened violation of any provision of

section 3901.20 of the Revised Code, if the court finds that the defendant has violated, is violating, or is threatening to violate such provision, that immediate and irreparable injury, loss, or damage will result if such relief is not granted, and that no adequate remedy at law exists to prevent such irreparable injury, loss, or damage.

(I) If the superintendent's position in initiating a matter in controversy pursuant to this section and section 3901.221 of the Revised Code was not substantially justified, upon motion of the person who prevailed in the hearing or in the appropriate court, if an adjudication order was appealed or a civil action was commenced, the superintendent or the court shall order the department of insurance to pay such person an amount, not in excess of one hundred thousand dollars, equal to one-half of the expenses reasonably incurred by the person in connection with the related proceedings. An award pursuant to this division may be reduced or denied if special circumstances make an award unjust or if the person engaged in conduct that unduly and unreasonably protracted the final resolution of the matter in controversy. If the department does not pay such award or no such funds are available, the award shall be treated as if it were a judgment under Chapter 2743. of the Revised Code and be payable in accordance with the procedures specified in section 2743.19 of the Revised Code, except that interest shall not be paid in relation to the award.

Sec. 3901.97. (A) As used in this section, "adverse benefit determination," "health benefit plan," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(B) The superintendent of insurance shall establish the

medical claims consumer assistance program, in accordance with section 2793 of the "Patient Protection and Affordable Care Act of 2010," 42 U.S.C. 300gg-93, to provide assistance to health benefit plan consumers in this state, including providing assistance receiving and responding to consumer inquiries and filing complaints concerning health insurance coverage. The program shall do all of the following:

(1) Provide consumers with information about a health plan issuer's internal appeal and external review processes for adverse benefit determinations required under Chapter 3922. of the Revised Code and assist consumers to file complaints and appeals under those processes;

(2) Assist consumers and health plan issuers to settle conflicts, disputed claims, and appealed adverse benefit determinations under a health benefit plan;

(3) Collect, track, and quantify problems and inquiries encountered by consumers relating to coverage under a health benefit plan;

(4) Educate consumers about their rights and responsibilities with respect to health benefit plans and health plan issuers;

(5) Assist consumers enrolling in a health benefit plan by providing information, referrals, or other similar assistance;

(6) Assist consumers in obtaining premium assistance tax credits authorized under section 1401 of the "Patient Protection and Affordable Care Act of 2010," 26 U.S.C. 36B;

(7) Through a comprehensive outreach program including, at minimum, electronic resources and a toll-free telephone number, provide public information about the services provided by the

program.

(C) The superintendent shall incorporate any existing programs or initiatives of the department of insurance that perform any of the functions enumerated in division (B) of this section into the medical claims consumer assistance program.

(D) The superintendent may contract with a nonprofit, independent entity to administer any of the superintendent's duties under the medical claims consumer assistance program. A health plan issuer, or any subsidiary or affiliate of a health plan issuer, licensed under Title XXXIX of the Revised Code may not serve as an entity under this division.

(E) Each health plan issuer in this state shall place a prominent, plain language notice about the medical claims consumer assistance program on the front page of all health benefit plan communications, including explanations of benefits, adverse benefit determination notices, and other plan-related communications.

(F) The superintendent shall collaborate with other state and local agencies as necessary to fulfill the duties of this section.

Sec. 3922.07. In addition to the information provided under division (D)(1)(b) of section 3922.05, division (B) of section 3922.08, division (C) of section 3922.09, and division (D) of section 3922.10 of the Revised Code, an assigned independent review organization, to the extent that such documents are available and appropriate, shall consider all of the following when conducting its review:

(A) The covered person's medical records;

(B) The attending health care professional's

recommendation;

(C) Consulting reports from appropriate health care professionals and other documents submitted by the health plan issuer, covered person, or covered person's treating provider;

(D) The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of the plan;

(E) The most appropriate practice guidelines, including evidence-based standards, and practice guidelines developed by the federal government, and national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization;

(G) The opinion of the independent review organization's clinical reviewer or reviewers after considering the other sources described in this section;

(H) Any evidence demonstrating intent on the part of the health plan issuer to improperly deny, reduce, or terminate the requested health care service or payment to a covered person under a health benefit plan.

Sec. 3922.171. (A) In addition to the data and reports required by section 3922.17 of the Revised Code, the superintendent of insurance shall maintain the following records submitted by health plan issuers pursuant to division (B) of this section:

(1) The number, percentage of total health benefit plan

claims, and type of adverse benefit determinations made by the health plan issuer during the previous calendar year;

(2) The number, percentage of total health benefit plan claims, and type of adverse benefit determinations that the superintendent found to be wrongful under section 3901.216 of the Revised Code during the previous calendar year.

(B) Each health plan issuer shall submit the data required under division (A)(1) of this section to the superintendent, in the form and manner required by the superintendent.

(C)(1) Beginning one year after the effective date of this section and annually thereafter, the superintendent shall submit a report with the following information about health benefit plan claims in this state during the previous calendar year:

(a) The total number and type of adverse benefit determinations made by health plan issuers in this state;

(b) The number and type of adverse benefit determinations in this state found by the superintendent to be wrongful under section 3901.216 of the Revised Code during the previous calendar year, reported as the total number of wrongful determinations and as a percentage of the total adverse benefit determinations during that calendar year;

(c) The number and type of adverse benefit determinations reported by consumers to the medical claims consumer assistance program established under section 3901.97 of the Revised Code;

(d) Of the number in division (C)(3) of this section, the number, type, and percentage of that number that were found to be wrongful by the superintendent under section 3901.216 of the Revised Code;

(e) Information and outcomes of any investigations conducted by the department of that health plan issuer for violations of Title XXXIX of the Revised Code.

(2) The superintendent shall submit the report required by division (C)(1) of this section to the attorney general, the governor, the president and minority leader of the senate, and the speaker and minority leader of the house of representatives. The superintendent also shall post the report on its public web site in a machine readable format.

(3) The superintendent shall annually review and update the data included in division (C)(1) of this section.

(D) If the superintendent finds that a health plan issuer has made wrongful adverse benefit determinations under section 3901.216 of the Revised Code in more than the median percentage of wrongful determinations made in this state by all health plan issuers in that calendar year, the superintendent shall review the wrongful adverse benefit determinations and report that information to the attorney general, the governor, the president and minority leader of the senate, and the speaker and minority leader of the house of representatives.

(E) The superintendent shall collaborate with other state and local agencies as necessary to fulfill the duties of this section.

Section 2. That existing sections 3901.22 and 3922.07 of the Revised Code are hereby repealed.

Section 3. This act shall be known as the Fair Health Claims Act.