

As Introduced

**136th General Assembly
Regular Session
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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 1
sections 3901.216, 3901.97, and 3922.171 of the 2
Revised Code to establish a medical claims 3
consumer assistance program, to prohibit health 4
insurers from improperly denying health claims, 5
and to name this act the Fair Health Claims Act. 6

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

Section 1. That sections 3901.22 and 3922.07 be amended 7
and sections 3901.216, 3901.97, and 3922.171 of the Revised Code 8
be enacted to read as follows: 9

Sec. 3901.216. (A) As used in this section, "covered 10
person," "health benefit plan," and "health plan issuer" have 11
the same meanings as in section 3922.01 of the Revised Code. 12

(B) A health plan issuer shall not wrongfully deny, 13
reduce, or terminate a requested health care service or payment 14
that is covered under a health benefit plan. 15

(C) A violation of this section is subject to the 16
procedures and penalties set forth in section 3901.22 of the 17
Revised Code, except as provided in this division. To the extent 18
that any of the provisions of this division conflict with 19

section 3901.22 of the Revised Code, the provisions of this 20
division apply. 21

(1) If the superintendent of insurance finds that a health 22
plan issuer has violated this section, the superintendent may 23
request the attorney general to commence and prosecute an action 24
or proceeding in the name of the state against the health plan 25
issuer. In addition to the penalties imposed by section 3901.22 26
of the Revised Code, the court may do all of the following in 27
such an action: 28

(a) Order the health plan issuer to pay to the covered 29
person double the amount of the wrongful denial, reduction, or 30
termination of a requested health care service or payment, plus 31
all expenses reasonably incurred by the covered person to retain 32
attorneys, actuaries, accountants, and other experts to assist 33
in the matter; 34

(b) Impose damages to be paid by the health plan issuer to 35
the covered person, in an amount to be determined by the court; 36

(c) Impose a civil penalty of not more than twenty-five 37
thousand dollars for each violation. 38

(2) The court may impose additional penalties against a 39
health plan issuer for repeated violations of this section. 40

(3) When imposing penalties under division (C) (1) or (2) 41
of this section, the court shall consider the factors listed in 42
division (E) of this section. 43

(D) Beginning one year after the effective date of this 44
section and annually thereafter, the superintendent shall 45
increase any penalty amounts specified in division (C) of this 46
section by the higher of the average rate of change in health 47
insurance premium rates in the individual and small group 48

marketplaces in this state or the current penalty amounts 49
increased by the rate of inflation for health insurance, as 50
indicated in the consumer price index for all urban consumers as 51
published by the United States bureau of labor statistics. 52

(E) In determining penalties under under this section or 53
section 3901.22 of the Revised Code, the superintendent or court 54
shall consider all of the following factors: 55

(1) The nature, scope, and gravity of the violation; 56

(2) The severity of the harm to the covered person, 57
including loss of life or health, emotional distress, and 58
financial harm; 59

(3) The nature and extent to which the health plan issuer 60
cooperates with the department of insurance during an 61
investigation of the violation; 62

(4) The nature and extent to which the health plan issuer 63
aggravated or mitigated any injury or damage caused by the 64
violation; 65

(5) The nature and extent to which the health plan issuer 66
has taken corrective action to ensure such a violation will not 67
recur; 68

(6) Evidence of the good or bad faith, intent, or 69
willfulness of the health plan issuer; 70

(7) The health plan issuer's history of violations of this 71
section and whether the alleged violation is an isolated 72
incident; 73

(8) The financial status of the health plan issuer and its 74
affiliates, including its reserves, financial solvency, excess 75
revenues, or other financial factors; 76

(9) The cost of the health care service in question, 77
including whether a penalty is commensurate with or exceeds the 78
cost of the service and the cost based on the number of covered 79
persons affected; 80

(10) The number of covered persons affected; 81

(11) The frequency of the violation, based on the number 82
of days of the violation or the estimated number of incidents; 83

(12) The severity of the potential harm resulting from the 84
violation, including loss of life or health, emotional distress, 85
or financial harm to covered persons; 86

(13) The amount of a financial penalty necessary to deter 87
similar violations in the future. 88

Sec. 3901.22. Except as provided in section 3901.216 of 89
the Revised Code, all of the following apply to violations of 90
section 3901.20 of the Revised Code: 91

(A) The superintendent of insurance may conduct hearings 92
to determine whether violations of section 3901.20 of the 93
Revised Code have occurred. Any person aggrieved with respect to 94
any act that the person believes to be an unfair or deceptive 95
act or practice in the business of insurance, as defined in 96
section 3901.21 or 3901.211 of the Revised Code or in any rule 97
of the superintendent, may make written application to the 98
superintendent for a hearing to determine if there has been a 99
violation of section 3901.20 of the Revised Code. The 100
application shall specify the grounds to be relied upon by the 101
applicant. If the superintendent finds that the application is 102
made in good faith, that the applicant would be so aggrieved if 103
the applicant's grounds are established, and that such grounds 104
otherwise justify holding such a hearing, the superintendent 105

shall hold a hearing to determine whether the act specified in 106
the application is a violation of section 3901.20 of the Revised 107
Code. Notice of any hearing held under the authority of this 108
section, the conduct of the hearing, the orders issued pursuant 109
to it, the review of the orders and all other matters relating 110
to the holding of the hearing shall be governed by Chapter 119. 111
of the Revised Code. 112

(B) Upon good cause shown, the superintendent shall permit 113
any person to intervene, appear, and be heard at the hearing, 114
either in person or by counsel. 115

(C) The superintendent shall send a copy of the order to 116
those persons intervening in the hearing. 117

(D) If the superintendent, by written order, finds that 118
any person has violated section 3901.20 of the Revised Code, the 119
superintendent shall issue an order requiring that person to 120
cease and desist from engaging in the violation. In addition, 121
the superintendent may impose any or all of the following 122
administrative remedies upon the person: 123

(1) The superintendent may suspend or revoke the person's 124
license to engage in the business of insurance; 125

(2) The superintendent may order that an insurance company 126
or insurance agency not employ the person or permit the person 127
to serve as a director, consultant, or in any other capacity for 128
such time as the superintendent determines would serve the 129
public interest. No application for termination of such an order 130
for an indefinite time shall be filed within two years of its 131
effective date. 132

(3) The superintendent may order the person to return any 133
payments received by the person as a result of the violation; 134

(4) If the superintendent issues an order pursuant to 135
division (D) (3) of this section, the superintendent shall order 136
the person to pay statutory interest on such payments. 137

If the superintendent does not issue orders pursuant to 138
divisions (D) (3) and (4) of this section, the superintendent 139
shall expressly state in the cease-and-desist order the reasons 140
for not issuing such orders. 141

(5) The superintendent may order the person to pay to the 142
state treasury for credit to the department's operating fund an 143
amount, not in excess of one hundred thousand dollars, equal to 144
one-half of the expenses reasonably incurred by the 145
superintendent to retain attorneys, actuaries, accountants, and 146
other experts not otherwise a part of the superintendent's staff 147
to assist directly in the conduct of any investigations and 148
hearings conducted with respect to violations committed by the 149
person. 150

(E) If the superintendent has reasonable cause to believe 151
that an order issued pursuant to division (D) of this section 152
has been violated in whole or in part, the superintendent may, 153
unless such order is stayed by a court of competent 154
jurisdiction, request the attorney general to commence and 155
prosecute any appropriate action or proceeding in the name of 156
the state against the person. 157

Such action may include, but need not be limited to, the 158
commencement of a class action under Civil Rule 23 on behalf of 159
policyholders, subscribers, applicants for policies or 160
contracts, or other insurance consumers for damages caused by or 161
unjust enrichment received as a result of the violation. 162

(F) In addition to any penalties imposed pursuant to this 163

chapter, the court may, in an action brought pursuant to 164
division (E) of this section, impose any of the following: 165

(1) For each act or practice found to be in violation of 166
section 3901.20 of the Revised Code, a civil penalty of not more 167
than three thousand five hundred dollars for each violation but 168
not to exceed an aggregate penalty of thirty-five thousand 169
dollars in any six-month period, provided that a series of 170
similar acts or practices prohibited by section 3901.20 of the 171
Revised Code and committed by the same person but not in 172
separate insurance sales transactions shall be considered a 173
single violation; 174

(2) For each violation of a cease and desist order issued 175
by the superintendent pursuant to this section, a civil penalty 176
of not more than ten thousand dollars; 177

(3) In addition to any other appropriate relief, the court 178
may order any or all of the remedies specified in division (D) 179
of this section. 180

(G) The superintendent, under a settlement agreement to 181
which a person has consented in writing for the purpose of 182
assuring the person's correction of a series of offenses and 183
future compliance with the laws of this state relating to the 184
business of insurance, may impose a single penalty in whatever 185
amount the parties determine to be justified under the 186
circumstances. 187

(H) A court of common pleas, in a civil action commenced 188
by the attorney general on behalf of the superintendent under 189
Civil Rule 65, may grant a temporary restraining order, 190
preliminary injunction, or permanent injunction to restrain or 191
prevent a violation or threatened violation of any provision of 192

section 3901.20 of the Revised Code, if the court finds that the 193
defendant has violated, is violating, or is threatening to 194
violate such provision, that immediate and irreparable injury, 195
loss, or damage will result if such relief is not granted, and 196
that no adequate remedy at law exists to prevent such 197
irreparable injury, loss, or damage. 198

(I) If the superintendent's position in initiating a 199
matter in controversy pursuant to this section and section 200
3901.221 of the Revised Code was not substantially justified, 201
upon motion of the person who prevailed in the hearing or in the 202
appropriate court, if an adjudication order was appealed or a 203
civil action was commenced, the superintendent or the court 204
shall order the department of insurance to pay such person an 205
amount, not in excess of one hundred thousand dollars, equal to 206
one-half of the expenses reasonably incurred by the person in 207
connection with the related proceedings. An award pursuant to 208
this division may be reduced or denied if special circumstances 209
make an award unjust or if the person engaged in conduct that 210
unduly and unreasonably protracted the final resolution of the 211
matter in controversy. If the department does not pay such award 212
or no such funds are available, the award shall be treated as if 213
it were a judgment under Chapter 2743. of the Revised Code and 214
be payable in accordance with the procedures specified in 215
section 2743.19 of the Revised Code, except that interest shall 216
not be paid in relation to the award. 217

Sec. 3901.97. (A) As used in this section, "adverse 218
benefit determination," "health benefit plan," and "health plan 219
issuer" have the same meanings as in section 3922.01 of the 220
Revised Code. 221

(B) The superintendent of insurance shall establish the 222

<u>medical claims consumer assistance program, in accordance with</u>	223
<u>section 2793 of the "Patient Protection and Affordable Care Act</u>	224
<u>of 2010," 42 U.S.C. 300gg-93, to provide assistance to health</u>	225
<u>benefit plan consumers in this state, including providing</u>	226
<u>assistance receiving and responding to consumer inquiries and</u>	227
<u>filing complaints concerning health insurance coverage. The</u>	228
<u>program shall do all of the following:</u>	229
<u>(1) Provide consumers with information about a health plan</u>	230
<u>issuer's internal appeal and external review processes for</u>	231
<u>adverse benefit determinations required under Chapter 3922. of</u>	232
<u>the Revised Code and assist consumers to file complaints and</u>	233
<u>appeals under those processes;</u>	234
<u>(2) Assist consumers and health plan issuers to settle</u>	235
<u>conflicts, disputed claims, and appealed adverse benefit</u>	236
<u>determinations under a health benefit plan;</u>	237
<u>(3) Collect, track, and quantify problems and inquiries</u>	238
<u>encountered by consumers relating to coverage under a health</u>	239
<u>benefit plan;</u>	240
<u>(4) Educate consumers about their rights and</u>	241
<u>responsibilities with respect to health benefit plans and health</u>	242
<u>plan issuers;</u>	243
<u>(5) Assist consumers enrolling in a health benefit plan by</u>	244
<u>providing information, referrals, or other similar assistance;</u>	245
<u>(6) Assist consumers in obtaining premium assistance tax</u>	246
<u>credits authorized under section 1401 of the "Patient Protection</u>	247
<u>and Affordable Care Act of 2010," 26 U.S.C. 36B;</u>	248
<u>(7) Through a comprehensive outreach program including, at</u>	249
<u>minimum, electronic resources and a toll-free telephone number,</u>	250
<u>provide public information about the services provided by the</u>	251

<u>program.</u>	252
<u>(C) The superintendent shall incorporate any existing</u>	253
<u>programs or initiatives of the department of insurance that</u>	254
<u>perform any of the functions enumerated in division (B) of this</u>	255
<u>section into the medical claims consumer assistance program.</u>	256
<u>(D) The superintendent may contract with a nonprofit,</u>	257
<u>independent entity to administer any of the superintendent's</u>	258
<u>duties under the medical claims consumer assistance program. A</u>	259
<u>health plan issuer, or any subsidiary or affiliate of a health</u>	260
<u>plan issuer, licensed under Title XXXIX of the Revised Code may</u>	261
<u>not serve as an entity under this division.</u>	262
<u>(E) Each health plan issuer in this state shall place a</u>	263
<u>prominent, plain language notice about the medical claims</u>	264
<u>consumer assistance program on the front page of all health</u>	265
<u>benefit plan communications, including explanations of benefits,</u>	266
<u>adverse benefit determination notices, and other plan-related</u>	267
<u>communications.</u>	268
<u>(F) The superintendent shall collaborate with other state</u>	269
<u>and local agencies as necessary to fulfill the duties of this</u>	270
<u>section.</u>	271
Sec. 3922.07. In addition to the information provided	272
under division (D) (1) (b) of section 3922.05, division (B) of	273
section 3922.08, division (C) of section 3922.09, and division	274
(D) of section 3922.10 of the Revised Code, an assigned	275
independent review organization, to the extent that such	276
documents are available and appropriate, shall consider all of	277
the following when conducting its review:	278
(A) The covered person's medical records;	279
(B) The attending health care professional's	280

recommendation;	281
(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;	282 283 284
(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;	285 286 287 288
(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;	289 290 291 292
(F) Any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization;	293 294 295
(G) The opinion of the independent review organization's clinical reviewer or reviewers after considering the other sources described in this section;	296 297 298
<u>(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.</u>	299 300 301 302
Sec. 3922.171. <u>(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:</u>	303 304 305 306 307
<u>(1) The number, percentage of total health benefit plan</u>	308

claims, and type of adverse benefit determinations made by the 309
health plan issuer during the previous calendar year; 310

(2) The number, percentage of total health benefit plan 311
claims, and type of adverse benefit determinations that the 312
superintendent found to be wrongful under section 3901.216 of 313
the Revised Code during the previous calendar year. 314

(B) Each health plan issuer shall submit the data required 315
under division (A) (1) of this section to the superintendent, in 316
the form and manner required by the superintendent. 317

(C) (1) Beginning one year after the effective date of this 318
section and annually thereafter, the superintendent shall submit 319
a report with the following information about health benefit 320
plan claims in this state during the previous calendar year: 321

(a) The total number and type of adverse benefit 322
determinations made by health plan issuers in this state; 323

(b) The number and type of adverse benefit determinations 324
in this state found by the superintendent to be wrongful under 325
section 3901.216 of the Revised Code during the previous 326
calendar year, reported as the total number of wrongful 327
determinations and as a percentage of the total adverse benefit 328
determinations during that calendar year; 329

(c) The number and type of adverse benefit determinations 330
reported by consumers to the medical claims consumer assistance 331
program established under section 3901.97 of the Revised Code; 332

(d) Of the number in division (C) (3) of this section, the 333
number, type, and percentage of that number that were found to 334
be wrongful by the superintendent under section 3901.216 of the 335
Revised Code; 336

(e) Information and outcomes of any investigations 337
conducted by the department of that health plan issuer for 338
violations of Title XXXIX of the Revised Code. 339

(2) The superintendent shall submit the report required by 340
division (C) (1) of this section to the attorney general, the 341
governor, the president and minority leader of the senate, and 342
the speaker and minority leader of the house of representatives. 343
The superintendent also shall post the report on its public web 344
site in a machine readable format. 345

(3) The superintendent shall annually review and update 346
the data included in division (C) (1) of this section. 347

(D) If the superintendent finds that a health plan issuer 348
has made wrongful adverse benefit determinations under section 349
3901.216 of the Revised Code in more than the median percentage 350
of wrongful determinations made in this state by all health plan 351
issuers in that calendar year, the superintendent shall review 352
the wrongful adverse benefit determinations and report that 353
information to the attorney general, the governor, the president 354
and minority leader of the senate, and the speaker and minority 355
leader of the house of representatives. 356

(E) The superintendent shall collaborate with other state 357
and local agencies as necessary to fulfill the duties of this 358
section. 359

Section 2. That existing sections 3901.22 and 3922.07 of 360
the Revised Code are hereby repealed. 361

Section 3. This act shall be known as the Fair Health 362
Claims Act. 363