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Representative DeVitis

**Cosponsors: Representatives Blessing, Scherer, Roegner, Duffey, Buchy,
Schuring, Johnson, T., Hackett, Cera, Grossman, Amstutz, Green, Hagan, Hood,
Perales, Retherford, Terhar, Young**

A BILL

To amend sections 1753.07, 1753.09, 3901.21, 1
3963.01, 3963.02, and 3963.03 of the Revised 2
Code to prohibit a health insurer from 3
establishing a fee schedule for dental providers 4
for services that are not covered by any 5
contract or participating provider agreement 6
between the health insurer and the dental 7
provider. 8

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

Section 1. That sections 1753.07, 1753.09, 3901.21, 9
3963.01, 3963.02, and 3963.03 of the Revised Code be amended to 10
read as follows: 11

Sec. 1753.07. (A) (1) Prior to entering into a 12
participation contract with a provider under section 1751.13 of 13
the Revised Code, a health insuring corporation shall disclose 14
basic information regarding its programs and procedures to the 15
provider. The information shall include all of the following: 16

(a) How a participating provider is reimbursed for the 17

participating provider's services, including the range and 18
structure of any financial risk sharing arrangements, a 19
description of any incentive plans, and, if reimbursed according 20
to a type of fee-for-service arrangement, the level of 21
reimbursement for the participating provider's services; 22

(b) Insofar as division (A) (1) of section 3963.03 of the 23
Revised Code is applicable, all of the information that is 24
described in that division and is not included in division (A) 25
(1) (a) of this section. 26

(2) Prior to entering into a participation contract with a 27
provider under section 1751.13 of the Revised Code, a health 28
insuring corporation shall disclose the following information 29
upon the provider's request: 30

(a) How referrals to other participating providers or to 31
nonparticipating providers are made; 32

(b) The availability of dispute resolution procedures and 33
the potential for cost to be incurred; 34

(c) How a participating provider's name and address will 35
be used in marketing materials. 36

(B) A health insuring corporation shall provide all of the 37
following to a participating provider: 38

(1) Any material incorporated by reference into the 39
participation contract, that is not otherwise available as a 40
public record, if such material affects the participating 41
provider; 42

(2) Administrative manuals related to provider 43
participation, if any; 44

(3) Insofar as division (B) of section 3963.03 of the 45

Revised Code is applicable, the summary disclosure form with the disclosures required under that division;

(4) A signed and dated copy of the final participation contract.

(C) ~~Nothing Except as otherwise provided in division (E) of section 3963.02 of the Revised Code, nothing~~ in this section requires a health insuring corporation providing specialty health care services or supplemental health care services to disclose the health insuring corporation's aggregate maximum allowable fee table used to determine providers' fees or fee schedules.

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

(B) (1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the

medical director the reason or reasons for the termination. 76

(2) If a satisfactory resolution of a participating 77
provider's appeal cannot be reached under division (B) (1) of 78
this section, the participating provider may appeal the 79
termination to a panel composed of participating providers who 80
have comparable or higher levels of education and training than 81
the participating provider making the appeal. A representative 82
of the participating provider's specialty shall be a member of 83
the panel, if possible. This panel shall hold a hearing, and 84
shall render its recommendation in the appeal within thirty days 85
after holding the hearing. The recommendation shall be presented 86
to the medical director and to the participating provider. 87

(3) The medical director shall review and consider the 88
panel's recommendation before making a decision. The decision 89
rendered by the medical director shall be final. 90

(C) A provider's status as a participating provider shall 91
remain in effect during the appeal process set forth in division 92
(B) of this section unless the termination was based on any of 93
the reasons listed in division (D) of this section. 94

(D) Notwithstanding division (A) of this section, a 95
provider's participation may be immediately terminated if the 96
participating provider's conduct presents an imminent risk of 97
harm to an enrollee or enrollees; or if there has occurred 98
unacceptable quality of care, fraud, patient abuse, loss of 99
clinical privileges, loss of professional liability coverage, 100
incompetence, or loss of authority to practice in the 101
participating provider's field; or if a governmental action has 102
impaired the participating provider's ability to practice. 103

(E) Divisions (A) to (D) of this section apply only to 104

providers who are natural persons. 105

(F) (1) Nothing in this section prohibits a health insuring 106
corporation from rejecting a provider's application for 107
participation, or from terminating a participating provider's 108
contract, if the health insuring corporation determines that the 109
health care needs of its enrollees are being met and no need 110
exists for the provider's or participating provider's services. 111

(2) Nothing in this section shall be construed as 112
prohibiting a health insuring corporation from terminating a 113
participating provider who does not meet the terms and 114
conditions of the participating provider's contract. 115

(3) Nothing in this section shall be construed as 116
prohibiting a health insuring corporation from terminating a 117
participating provider's contract pursuant to any provision of 118
the contract described in division ~~(E)~~(F) (2) of section 3963.02 119
of the Revised Code, except that, notwithstanding any provision 120
of a contract described in that division, this section applies 121
to the termination of a participating provider's contract for 122
any of the causes described in divisions (A), (D), and (F) (1) 123
and (2) of this section. 124

(G) The superintendent of insurance may adopt rules as 125
necessary to implement and enforce sections 1753.06, 1753.07, 126
and 1753.09 of the Revised Code. Such rules shall be adopted in 127
accordance with Chapter 119. of the Revised Code. 128

Sec. 3901.21. The following are hereby defined as unfair 129
and deceptive acts or practices in the business of insurance: 130

(A) Making, issuing, circulating, or causing or permitting 131
to be made, issued, or circulated, or preparing with intent to 132
so use, any estimate, illustration, circular, or statement 133

misrepresenting the terms of any policy issued or to be issued 134
or the benefits or advantages promised thereby or the dividends 135
or share of the surplus to be received thereon, or making any 136
false or misleading statements as to the dividends or share of 137
surplus previously paid on similar policies, or making any 138
misleading representation or any misrepresentation as to the 139
financial condition of any insurer as shown by the last 140
preceding verified statement made by it to the insurance 141
department of this state, or as to the legal reserve system upon 142
which any life insurer operates, or using any name or title of 143
any policy or class of policies misrepresenting the true nature 144
thereof, or making any misrepresentation or incomplete 145
comparison to any person for the purpose of inducing or tending 146
to induce such person to purchase, amend, lapse, forfeit, 147
change, or surrender insurance. 148

Any written statement concerning the premiums for a policy 149
which refers to the net cost after credit for an assumed 150
dividend, without an accurate written statement of the gross 151
premiums, cash values, and dividends based on the insurer's 152
current dividend scale, which are used to compute the net cost 153
for such policy, and a prominent warning that the rate of 154
dividend is not guaranteed, is a misrepresentation for the 155
purposes of this division. 156

(B) Making, publishing, disseminating, circulating, or 157
placing before the public or causing, directly or indirectly, to 158
be made, published, disseminated, circulated, or placed before 159
the public, in a newspaper, magazine, or other publication, or 160
in the form of a notice, circular, pamphlet, letter, or poster, 161
or over any radio station, or in any other way, or preparing 162
with intent to so use, an advertisement, announcement, or 163
statement containing any assertion, representation, or 164

statement, with respect to the business of insurance or with 165
respect to any person in the conduct of the person's insurance 166
business, which is untrue, deceptive, or misleading. 167

(C) Making, publishing, disseminating, or circulating, 168
directly or indirectly, or aiding, abetting, or encouraging the 169
making, publishing, disseminating, or circulating, or preparing 170
with intent to so use, any statement, pamphlet, circular, 171
article, or literature, which is false as to the financial 172
condition of an insurer and which is calculated to injure any 173
person engaged in the business of insurance. 174

(D) Filing with any supervisory or other public official, 175
or making, publishing, disseminating, circulating, or delivering 176
to any person, or placing before the public, or causing directly 177
or indirectly to be made, published, disseminated, circulated, 178
delivered to any person, or placed before the public, any false 179
statement of financial condition of an insurer. 180

Making any false entry in any book, report, or statement 181
of any insurer with intent to deceive any agent or examiner 182
lawfully appointed to examine into its condition or into any of 183
its affairs, or any public official to whom such insurer is 184
required by law to report, or who has authority by law to 185
examine into its condition or into any of its affairs, or, with 186
like intent, willfully omitting to make a true entry of any 187
material fact pertaining to the business of such insurer in any 188
book, report, or statement of such insurer, or mutilating, 189
destroying, suppressing, withholding, or concealing any of its 190
records. 191

(E) Issuing or delivering or permitting agents, officers, 192
or employees to issue or deliver agency company stock or other 193
capital stock or benefit certificates or shares in any common- 194

law corporation or securities or any special or advisory board 195
contracts or other contracts of any kind promising returns and 196
profits as an inducement to insurance. 197

(F) Making or permitting any unfair discrimination among 198
individuals of the same class and equal expectation of life in 199
the rates charged for any contract of life insurance or of life 200
annuity or in the dividends or other benefits payable thereon, 201
or in any other of the terms and conditions of such contract. 202

(G) (1) Except as otherwise expressly provided by law, 203
knowingly permitting or offering to make or making any contract 204
of life insurance, life annuity or accident and health 205
insurance, or agreement as to such contract other than as 206
plainly expressed in the contract issued thereon, or paying or 207
allowing, or giving or offering to pay, allow, or give, directly 208
or indirectly, as inducement to such insurance, or annuity, any 209
rebate of premiums payable on the contract, or any special favor 210
or advantage in the dividends or other benefits thereon, or any 211
valuable consideration or inducement whatever not specified in 212
the contract; or giving, or selling, or purchasing, or offering 213
to give, sell, or purchase, as inducement to such insurance or 214
annuity or in connection therewith, any stocks, bonds, or other 215
securities, or other obligations of any insurance company or 216
other corporation, association, or partnership, or any dividends 217
or profits accrued thereon, or anything of value whatsoever not 218
specified in the contract. 219

(2) Nothing in division (F) or division (G) (1) of this 220
section shall be construed as prohibiting any of the following 221
practices: (a) in the case of any contract of life insurance or 222
life annuity, paying bonuses to policyholders or otherwise 223
abating their premiums in whole or in part out of surplus 224

accumulated from nonparticipating insurance, provided that any 225
such bonuses or abatement of premiums shall be fair and 226
equitable to policyholders and for the best interests of the 227
company and its policyholders; (b) in the case of life insurance 228
policies issued on the industrial debit plan, making allowance 229
to policyholders who have continuously for a specified period 230
made premium payments directly to an office of the insurer in an 231
amount which fairly represents the saving in collection 232
expenses; (c) readjustment of the rate of premium for a group 233
insurance policy based on the loss or expense experience 234
thereunder, at the end of the first or any subsequent policy 235
year of insurance thereunder, which may be made retroactive only 236
for such policy year. 237

(H) Making, issuing, circulating, or causing or permitting 238
to be made, issued, or circulated, or preparing with intent to 239
so use, any statement to the effect that a policy of life 240
insurance is, is the equivalent of, or represents shares of 241
capital stock or any rights or options to subscribe for or 242
otherwise acquire any such shares in the life insurance company 243
issuing that policy or any other company. 244

(I) Making, issuing, circulating, or causing or permitting 245
to be made, issued or circulated, or preparing with intent to so 246
issue, any statement to the effect that payments to a 247
policyholder of the principal amounts of a pure endowment are 248
other than payments of a specific benefit for which specific 249
premiums have been paid. 250

(J) Making, issuing, circulating, or causing or permitting 251
to be made, issued, or circulated, or preparing with intent to 252
so use, any statement to the effect that any insurance company 253
was required to change a policy form or related material to 254

comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance.

(K) Aiding or abetting another to violate this section.

(L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder.

(M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder, or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever.

(N) Refusing to make available disability income insurance solely because the applicant's principal occupation is that of managing a household.

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such

benefits under an individual sickness and accident insurance 284
policy issued to an individual who is not a federally eligible 285
individual or a nonemployer-related group sickness and accident 286
insurance policy, but in no event shall such waiting period 287
exceed two hundred seventy days. 288

For purposes of division (O) of this section, "federally 289
eligible individual" means an eligible individual as defined in 290
45 C.F.R. 148.103. 291

(P) Using, or permitting to be used, a pattern settlement 292
as the basis of any offer of settlement. As used in this 293
division, "pattern settlement" means a method by which liability 294
is routinely imputed to a claimant without an investigation of 295
the particular occurrence upon which the claim is based and by 296
using a predetermined formula for the assignment of liability 297
arising out of occurrences of a similar nature. Nothing in this 298
division shall be construed to prohibit an insurer from 299
determining a claimant's liability by applying formulas or 300
guidelines to the facts and circumstances disclosed by the 301
insurer's investigation of the particular occurrence upon which 302
a claim is based. 303

(Q) Refusing to insure, or refusing to continue to insure, 304
or limiting the amount, extent, or kind of life or sickness and 305
accident insurance or annuity coverage available to an 306
individual, or charging an individual a different rate for the 307
same coverage solely because of blindness or partial blindness. 308
With respect to all other conditions, including the underlying 309
cause of blindness or partial blindness, persons who are blind 310
or partially blind shall be subject to the same standards of 311
sound actuarial principles or actual or reasonably anticipated 312
actuarial experience as are sighted persons. Refusal to insure 313

includes, but is not limited to, denial by an insurer of 314
disability insurance coverage on the grounds that the policy 315
defines "disability" as being presumed in the event that the 316
eyesight of the insured is lost. However, an insurer may exclude 317
from coverage disabilities consisting solely of blindness or 318
partial blindness when such conditions existed at the time the 319
policy was issued. To the extent that the provisions of this 320
division may appear to conflict with any provision of section 321
3999.16 of the Revised Code, this division applies. 322

(R) (1) Directly or indirectly offering to sell, selling, 323
or delivering, issuing for delivery, renewing, or using or 324
otherwise marketing any policy of insurance or insurance product 325
in connection with or in any way related to the grant of a 326
student loan guaranteed in whole or in part by an agency or 327
commission of this state or the United States, except insurance 328
that is required under federal or state law as a condition for 329
obtaining such a loan and the premium for which is included in 330
the fees and charges applicable to the loan; or, in the case of 331
an insurer or insurance agent, knowingly permitting any lender 332
making such loans to engage in such acts or practices in 333
connection with the insurer's or agent's insurance business. 334

(2) Except in the case of a violation of division (G) of 335
this section, division (R) (1) of this section does not apply to 336
either of the following: 337

(a) Acts or practices of an insurer, its agents, 338
representatives, or employees in connection with the grant of a 339
guaranteed student loan to its insured or the insured's spouse 340
or dependent children where such acts or practices take place 341
more than ninety days after the effective date of the insurance; 342

(b) Acts or practices of an insurer, its agents, 343

representatives, or employees in connection with the 344
solicitation, processing, or issuance of an insurance policy or 345
product covering the student loan borrower or the borrower's 346
spouse or dependent children, where such acts or practices take 347
place more than one hundred eighty days after the date on which 348
the borrower is notified that the student loan was approved. 349

(S) Denying coverage, under any health insurance or health 350
care policy, contract, or plan providing family coverage, to any 351
natural or adopted child of the named insured or subscriber 352
solely on the basis that the child does not reside in the 353
household of the named insured or subscriber. 354

(T) (1) Using any underwriting standard or engaging in any 355
other act or practice that, directly or indirectly, due solely 356
to any health status-related factor in relation to one or more 357
individuals, does either of the following: 358

(a) Terminates or fails to renew an existing individual 359
policy, contract, or plan of health benefits, or a health 360
benefit plan issued to an employer, for which an individual 361
would otherwise be eligible; 362

(b) With respect to a health benefit plan issued to an 363
employer, excludes or causes the exclusion of an individual from 364
coverage under an existing employer-provided policy, contract, 365
or plan of health benefits. 366

(2) The superintendent of insurance may adopt rules in 367
accordance with Chapter 119. of the Revised Code for purposes of 368
implementing division (T) (1) of this section. 369

(3) For purposes of division (T) (1) of this section, 370
"health status-related factor" means any of the following: 371

(a) Health status; 372

(b) Medical condition, including both physical and mental illnesses;	373 374
(c) Claims experience;	375
(d) Receipt of health care;	376
(e) Medical history;	377
(f) Genetic information;	378
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	379 380
(h) Disability.	381
(U) With respect to a health benefit plan issued to a small employer, as those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code.	382 383 384 385 386
(V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code.	387 388 389 390
(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice.	391 392 393
(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company.	394 395 396 397
(Y) (1) (a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or	398 399

contract of life insurance, or limiting coverage under or 400
refusing to issue any individual policy or contract of health 401
insurance, for the reason that the insured or applicant for 402
insurance is or has been a victim of domestic violence; 403

(b) Adding a surcharge or rating factor to a premium of 404
any individual policy or contract of life or health insurance 405
for the reason that the insured or applicant for insurance is or 406
has been a victim of domestic violence; 407

(c) Denying coverage under, or limiting coverage under, 408
any policy or contract of life or health insurance, for the 409
reason that a claim under the policy or contract arises from an 410
incident of domestic violence; 411

(d) Inquiring, directly or indirectly, of an insured 412
under, or of an applicant for, a policy or contract of life or 413
health insurance, as to whether the insured or applicant is or 414
has been a victim of domestic violence, or inquiring as to 415
whether the insured or applicant has sought shelter or 416
protection from domestic violence or has sought medical or 417
psychological treatment as a victim of domestic violence. 418

(2) Nothing in division (Y) (1) of this section shall be 419
construed to prohibit an insurer from inquiring as to, or from 420
underwriting or rating a risk on the basis of, a person's 421
physical or mental condition, even if the condition has been 422
caused by domestic violence, provided that all of the following 423
apply: 424

(a) The insurer routinely considers the condition in 425
underwriting or in rating risks, and does so in the same manner 426
for a victim of domestic violence as for an insured or applicant 427
who is not a victim of domestic violence; 428

(b) The insurer does not refuse to issue any policy or 429
contract of life or health insurance or cancel or refuse to 430
renew any policy or contract of life insurance, solely on the 431
basis of the condition, except where such refusal to issue, 432
cancellation, or refusal to renew is based on sound actuarial 433
principles or is related to actual or reasonably anticipated 434
experience; 435

(c) The insurer does not consider a person's status as 436
being or as having been a victim of domestic violence, in 437
itself, to be a physical or mental condition; 438

(d) The underwriting or rating of a risk on the basis of 439
the condition is not used to evade the intent of division (Y) (1) 440
of this section, or of any other provision of the Revised Code. 441

(3) (a) Nothing in division (Y) (1) of this section shall be 442
construed to prohibit an insurer from refusing to issue a policy 443
or contract of life insurance insuring the life of a person who 444
is or has been a victim of domestic violence if the person who 445
committed the act of domestic violence is the applicant for the 446
insurance or would be the owner of the insurance policy or 447
contract. 448

(b) Nothing in division (Y) (2) of this section shall be 449
construed to permit an insurer to cancel or refuse to renew any 450
policy or contract of health insurance in violation of the 451
"Health Insurance Portability and Accountability Act of 1996," 452
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 453
manner that violates or is inconsistent with any provision of 454
the Revised Code that implements the "Health Insurance 455
Portability and Accountability Act of 1996." 456

(4) An insurer is immune from any civil or criminal 457

liability that otherwise might be incurred or imposed as a 458
result of any action taken by the insurer to comply with 459
division (Y) of this section. 460

(5) As used in division (Y) of this section, "domestic 461
violence" means any of the following acts: 462

(a) Knowingly causing or attempting to cause physical harm 463
to a family or household member; 464

(b) Recklessly causing serious physical harm to a family 465
or household member; 466

(c) Knowingly causing, by threat of force, a family or 467
household member to believe that the person will cause imminent 468
physical harm to the family or household member. 469

For the purpose of division (Y) (5) of this section, 470
"family or household member" has the same meaning as in section 471
2919.25 of the Revised Code. 472

Nothing in division (Y) (5) of this section shall be 473
construed to require, as a condition to the application of 474
division (Y) of this section, that the act described in division 475
(Y) (5) of this section be the basis of a criminal prosecution. 476

(Z) Disclosing a coroner's records by an insurer in 477
violation of section 313.10 of the Revised Code. 478

(AA) Making, issuing, circulating, or causing or 479
permitting to be made, issued, or circulated any statement or 480
representation that a life insurance policy or annuity is a 481
contract for the purchase of funeral goods or services. 482

(BB) (1) Setting or requiring the insurer's approval of 483
fees for dental services that are not covered dental services, 484
as defined in section 3963.01 of the Revised Code, or making 485

available any health benefit plan that sets fees for dental 486
services that are not covered dental care services. 487

(2) Nothing in division (BB)(1) of this section shall be 488
construed to apply to any health benefit plan subject to 489
regulation by the "Employee Retirement Income Security Act of 490
1974," 29 U.S.C. 1001, et seq., as amended. 491

(CC) With respect to private passenger automobile 492
insurance, charging premium rates that are excessive, 493
inadequate, or unfairly discriminatory, pursuant to division (D) 494
of section 3937.02 of the Revised Code, based solely on the 495
location of the residence of the insured. 496

The enumeration in sections 3901.19 to 3901.26 of the 497
Revised Code of specific unfair or deceptive acts or practices 498
in the business of insurance is not exclusive or restrictive or 499
intended to limit the powers of the superintendent of insurance 500
to adopt rules to implement this section, or to take action 501
under other sections of the Revised Code. 502

This section does not prohibit the sale of shares of any 503
investment company registered under the "Investment Company Act 504
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 505
policies, annuities, or other contracts described in section 506
3907.15 of the Revised Code. 507

As used in this section, "estimate," "statement," 508
"representation," "misrepresentation," "advertisement," or 509
"announcement" includes oral or written occurrences. 510

Sec. 3963.01. As used in this chapter: 511

(A) "Affiliate" means any person or entity that has 512
ownership or control of a contracting entity, is owned or 513
controlled by a contracting entity, or is under common ownership 514

or control with a contracting entity. 515

(B) "Basic health care services" has the same meaning as 516
in division (A) of section 1751.01 of the Revised Code, except 517
that it does not include any services listed in that division 518
that are provided by a pharmacist or nursing home. 519

(C) "Contracting entity" means any person that has a 520
primary business purpose of contracting with participating 521
providers for the delivery of health care services. 522

(D) "Covered dental services" means dental services for 523
which a reimbursement is available under an enrollee's health 524
benefit plan contract, or for which a reimbursement would be 525
available but for the application of contractual limitations 526
such as a deductible, copayment, coinsurance, waiting period, 527
annual or lifetime maximum, frequency limitation, alternative 528
benefit payment, or any other limitation. 529

(E) "Credentialing" means the process of assessing and 530
validating the qualifications of a provider applying to be 531
approved by a contracting entity to provide basic health care 532
services, specialty health care services, or supplemental health 533
care services to enrollees. 534

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes 535
billed by a participating provider on a claim for payment or a 536
practice that results in any of the following: 537

(1) Payment for some, but not all of the procedure codes 538
originally billed by a participating provider; 539

(2) Payment for a different procedure code than the 540
procedure code originally billed by a participating provider; 541

(3) A reduced payment as a result of services provided to 542

an enrollee that are claimed under more than one procedure code 543
on the same service date. 544

~~(F)~~(G) "Electronic claims transport" means to accept and 545
digitize claims or to accept claims already digitized, to place 546
those claims into a format that complies with the electronic 547
transaction standards issued by the United States department of 548
health and human services pursuant to the "Health Insurance 549
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 550
U.S.C. 1320d, et seq., as those electronic standards are 551
applicable to the parties and as those electronic standards are 552
updated from time to time, and to electronically transmit those 553
claims to the appropriate contracting entity, payer, or third- 554
party administrator. 555

~~(G)~~(H) "Enrollee" means any person eligible for health 556
care benefits under a health benefit plan, including an eligible 557
recipient of medicaid, and includes all of the following terms: 558

(1) "Enrollee" and "subscriber" as defined by section 559
1751.01 of the Revised Code; 560

(2) "Member" as defined by section 1739.01 of the Revised 561
Code; 562

(3) "Insured" and "plan member" pursuant to Chapter 3923. 563
of the Revised Code; 564

(4) "Beneficiary" as defined by section 3901.38 of the 565
Revised Code. 566

~~(H)~~(I) "Health care contract" means a contract entered 567
into, materially amended, or renewed between a contracting 568
entity and a participating provider for the delivery of basic 569
health care services, specialty health care services, or 570
supplemental health care services to enrollees. 571

~~(I)~~ (J) "Health care services" means basic health care services, specialty health care services, and supplemental health care services.

~~(J)~~ (K) "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:

(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense;

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A) (1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change;

(6) Changes to a health care contract described in 601
division (B) of section 3963.04 of the Revised Code. 602

~~(K)~~(L) "Participating provider" means a provider that has 603
a health care contract with a contracting entity and is entitled 604
to reimbursement for health care services rendered to an 605
enrollee under the health care contract. 606

~~(L)~~(M) "Payer" means any person that assumes the 607
financial risk for the payment of claims under a health care 608
contract or the reimbursement for health care services provided 609
to enrollees by participating providers pursuant to a health 610
care contract. 611

~~(M)~~(N) "Primary enrollee" means a person who is 612
responsible for making payments for participation in a health 613
care plan or an enrollee whose employment or other status is the 614
basis of eligibility for enrollment in a health care plan. 615

~~(N)~~(O) "Procedure codes" includes the American medical 616
association's current procedural terminology code, the American 617
dental association's current dental terminology, and the centers 618
for medicare and medicaid services health care common procedure 619
coding system. 620

~~(O)~~(P) "Product" means one of the following types of 621
categories of coverage for which a participating provider may be 622
obligated to provide health care services pursuant to a health 623
care contract: 624

(1) A health maintenance organization or other product 625
provided by a health insuring corporation; 626

(2) A preferred provider organization; 627

(3) Medicare; 628

(4) Medicaid; 629

(5) Workers' compensation. 630

~~(P)~~(Q) "Provider" means a physician, podiatrist, dentist, 631
chiropractor, optometrist, psychologist, physician assistant, 632
advanced practice registered nurse, occupational therapist, 633
massage therapist, physical therapist, licensed professional 634
counselor, licensed professional clinical counselor, hearing aid 635
dealer, orthotist, prosthetist, home health agency, hospice care 636
program, pediatric respite care program, or hospital, or a 637
provider organization or physician-hospital organization that is 638
acting exclusively as an administrator on behalf of a provider 639
to facilitate the provider's participation in health care 640
contracts. "Provider" does not mean a pharmacist, pharmacy, 641
nursing home, or a provider organization or physician-hospital 642
organization that leases the provider organization's or 643
physician-hospital organization's network to a third party or 644
contracts directly with employers or health and welfare funds. 645

~~(Q)~~(R) "Specialty health care services" has the same 646
meaning as in section 1751.01 of the Revised Code, except that 647
it does not include any services listed in division (B) of 648
section 1751.01 of the Revised Code that are provided by a 649
pharmacist or a nursing home. 650

~~(R)~~(S) "Supplemental health care services" has the same 651
meaning as in division (B) of section 1751.01 of the Revised 652
Code, except that it does not include any services listed in 653
that division that are provided by a pharmacist or nursing home. 654

Sec. 3963.02. (A) (1) No contracting entity shall sell, 655
rent, or give a third party the contracting entity's rights to a 656
participating provider's services pursuant to the contracting 657

entity's health care contract with the participating provider 658
unless one of the following applies: 659

(a) The third party accessing the participating provider's 660
services under the health care contract is an employer or other 661
entity providing coverage for health care services to its 662
employees or members, and that employer or entity has a contract 663
with the contracting entity or its affiliate for the 664
administration or processing of claims for payment for services 665
provided pursuant to the health care contract with the 666
participating provider. 667

(b) The third party accessing the participating provider's 668
services under the health care contract either is an affiliate 669
or subsidiary of the contracting entity or is providing 670
administrative services to, or receiving administrative services 671
from, the contracting entity or an affiliate or subsidiary of 672
the contracting entity. 673

(c) The health care contract specifically provides that it 674
applies to network rental arrangements and states that one 675
purpose of the contract is selling, renting, or giving the 676
contracting entity's rights to the services of the participating 677
provider, including other preferred provider organizations, and 678
the third party accessing the participating provider's services 679
is any of the following: 680

(i) A payer or a third-party administrator or other entity 681
responsible for administering claims on behalf of the payer; 682

(ii) A preferred provider organization or preferred 683
provider network that receives access to the participating 684
provider's services pursuant to an arrangement with the 685
preferred provider organization or preferred provider network in 686

a contract with the participating provider that is in compliance 687
with division (A) (1) (c) of this section, and is required to 688
comply with all of the terms, conditions, and affirmative 689
obligations to which the originally contracted primary 690
participating provider network is bound under its contract with 691
the participating provider, including, but not limited to, 692
obligations concerning patient steerage and the timeliness and 693
manner of reimbursement. 694

(iii) An entity that is engaged in the business of 695
providing electronic claims transport between the contracting 696
entity and the payer or third-party administrator and complies 697
with all of the applicable terms, conditions, and affirmative 698
obligations of the contracting entity's contract with the 699
participating provider including, but not limited to, 700
obligations concerning patient steerage and the timeliness and 701
manner of reimbursement. 702

(2) The contracting entity that sells, rents, or gives the 703
contracting entity's rights to the participating provider's 704
services pursuant to the contracting entity's health care 705
contract with the participating provider as provided in division 706
(A) (1) of this section shall do both of the following: 707

(a) Maintain a web page that contains a listing of third 708
parties described in divisions (A) (1) (b) and (c) of this section 709
with whom a contracting entity contracts for the purpose of 710
selling, renting, or giving the contracting entity's rights to 711
the services of participating providers that is updated at least 712
every six months and is accessible to all participating 713
providers, or maintain a toll-free telephone number accessible 714
to all participating providers by means of which participating 715
providers may access the same listing of third parties; 716

(b) Require that the third party accessing the 717
participating provider's services through the participating 718
provider's health care contract is obligated to comply with all 719
of the applicable terms and conditions of the contract, 720
including, but not limited to, the products for which the 721
participating provider has agreed to provide services, except 722
that a payer receiving administrative services from the 723
contracting entity or its affiliate shall be solely responsible 724
for payment to the participating provider. 725

(3) Any information disclosed to a participating provider 726
under this section shall be considered proprietary and shall not 727
be distributed by the participating provider. 728

(4) Except as provided in division (A)(1) of this section, 729
no entity shall sell, rent, or give a contracting entity's 730
rights to the participating provider's services pursuant to a 731
health care contract. 732

(B)(1) No contracting entity shall require, as a condition 733
of contracting with the contracting entity, that a participating 734
provider provide services for all of the products offered by the 735
contracting entity. 736

(2) Division (B)(1) of this section shall not be construed 737
to do any of the following: 738

(a) Prohibit any participating provider from voluntarily 739
accepting an offer by a contracting entity to provide health 740
care services under all of the contracting entity's products; 741

(b) Prohibit any contracting entity from offering any 742
financial incentive or other form of consideration specified in 743
the health care contract for a participating provider to provide 744
health care services under all of the contracting entity's 745

products; 746

(c) Require any contracting entity to contract with a 747
participating provider to provide health care services for less 748
than all of the contracting entity's products if the contracting 749
entity does not wish to do so. 750

(3) (a) Notwithstanding division (B) (2) of this section, no 751
contracting entity shall require, as a condition of contracting 752
with the contracting entity, that the participating provider 753
accept any future product offering that the contracting entity 754
makes. 755

(b) If a participating provider refuses to accept any 756
future product offering that the contracting entity makes, the 757
contracting entity may terminate the health care contract based 758
on the participating provider's refusal upon written notice to 759
the participating provider no sooner than one hundred eighty 760
days after the refusal. 761

(4) Once the contracting entity and the participating 762
provider have signed the health care contract, it is presumed 763
that the financial incentive or other form of consideration that 764
is specified in the health care contract pursuant to division 765
(B) (2) (b) of this section is the financial incentive or other 766
form of consideration that was offered by the contracting entity 767
to induce the participating provider to enter into the contract. 768

(C) No contracting entity shall require, as a condition of 769
contracting with the contracting entity, that a participating 770
provider waive or forego any right or benefit expressly 771
conferred upon a participating provider by state or federal law. 772
However, this division does not prohibit a contracting entity 773
from restricting a participating provider's scope of practice 774

for the services to be provided under the contract. 775

(D) No health care contract shall do any of the following: 776

(1) Prohibit any participating provider from entering into 777
a health care contract with any other contracting entity; 778

(2) Prohibit any contracting entity from entering into a 779
health care contract with any other provider; 780

(3) Preclude its use or disclosure for the purpose of 781
enforcing this chapter or other state or federal law, except 782
that a health care contract may require that appropriate 783
measures be taken to preserve the confidentiality of any 784
proprietary or trade-secret information. 785

(E) (1) No contracting entity shall require in any health 786
care contract that covers any dental services, either directly 787
or indirectly, that a participating provider who is a dentist 788
provide services to an enrollee at a fee set by, or a fee 789
subject to the approval of, the contracting entity unless the 790
dental services are covered dental services. 791

(2) To the extent that the provisions in division (E) (1) 792
of this section conflict with the provisions of the federal 793
"Employee Retirement Income Security Act of 1974," 29 U.S.C. 794
1001, et seq., as amended, the federal law shall control. 795

(F) (1) In addition to any other lawful reasons for 796
terminating a health care contract, a health care contract may 797
only be terminated under the circumstances described in division 798
(A) (3) of section 3963.04 of the Revised Code. 799

(2) If the health care contract provides for termination 800
for cause by either party, the health care contract shall state 801
the reasons that may be used for termination for cause, which 802

terms shall be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to division ~~(E)~~(F)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in divisions ~~(E)~~(F)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in divisions (A), (D), and (F) (1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division ~~(E)~~(F)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F) (1) and (2) of section 1753.09 of the Revised Code.

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause.

~~(F)~~(G)(1) Disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this

section to the prevailing party. 833

(2) The arbitrator shall make the arbitrator's decision in 834
an arbitration proceeding having due regard for any applicable 835
rules, bulletins, rulings, or decisions issued by the department 836
of insurance or any court concerning the enforcement of the 837
contract rights conferred by section 3963.02, divisions (A) and 838
(D) of section 3963.03, and section 3963.04 of the Revised Code. 839

(3) A party shall not simultaneously maintain an 840
arbitration proceeding as described in division ~~(F)~~(G)(1) of 841
this section and pursue a complaint with the superintendent of 842
insurance to investigate the subject matter of the arbitration 843
proceeding. However, if a complaint is filed with the department 844
of insurance, the superintendent may choose to investigate the 845
complaint or, after reviewing the complaint, advise the 846
complainant to proceed with arbitration to resolve the 847
complaint. The superintendent may request to receive a copy of 848
the results of the arbitration. If the superintendent of 849
insurance notifies an insurer or a health insuring corporation 850
in writing that the superintendent has initiated a market 851
conduct examination into the specific subject matter of the 852
arbitration proceeding pending against that insurer or health 853
insuring corporation, the arbitration proceeding shall be stayed 854
at the request of the insurer or health insuring corporation 855
pending the outcome of the market conduct investigation by the 856
superintendent. 857

Sec. 3963.03. (A) Each health care contract shall include 858
all of the following information: 859

(1) (a) Information sufficient for the participating 860
provider to determine the compensation or payment terms for 861
health care services, including all of the following, subject to 862

division (A) (1) (b) of this section: 863

(i) The manner of payment, such as fee-for-service, 864
capitation, or risk; 865

(ii) The fee schedule of procedure codes reasonably 866
expected to be billed by a participating provider's specialty 867
for services provided pursuant to the health care contract and 868
the associated payment or compensation for each procedure code. 869
A fee schedule may be provided electronically. Upon request, a 870
contracting entity shall provide a participating provider with 871
the fee schedule for any other procedure codes requested and a 872
written fee schedule, that shall not be required more frequently 873
than twice per year excluding when it is provided in connection 874
with any change to the schedule. This requirement may be 875
satisfied by providing a clearly understandable, readily 876
available mechanism, such as a specific web site address, that 877
allows a participating provider to determine the effect of 878
procedure codes on payment or compensation before a service is 879
provided or a claim is submitted. 880

(iii) The effect, if any, on payment or compensation if 881
more than one procedure code applies to the service also shall 882
be stated. This requirement may be satisfied by providing a 883
clearly understandable, readily available mechanism, such as a 884
specific web site address, that allows a participating provider 885
to determine the effect of procedure codes on payment or 886
compensation before a service is provided or a claim is 887
submitted. 888

(b) If the contracting entity is unable to include the 889
information described in ~~division~~ divisions (A) (1) (a) (ii) and 890
(iii) of this section, the contracting entity shall include both 891
of the following types of information instead: 892

(i) The methodology used to calculate any fee schedule, 893
such as relative value unit system and conversion factor or 894
percentage of billed charges. If applicable, the methodology 895
disclosure shall include the name of any relative value unit 896
system, its version, edition, or publication date, any 897
applicable conversion or geographic factor, and any date by 898
which compensation or fee schedules may be changed by the 899
methodology as anticipated at the time of contract. 900

(ii) The identity of any internal processing edits, 901
including the publisher, product name, version, and version 902
update of any editing software. 903

(c) If the contracting entity is not the payer and is 904
unable to include the information described in division (A) (1) 905
(a) or (b) of this section, then the contracting entity shall 906
provide by telephone a readily available mechanism, such as a 907
specific web site address, that allows the participating 908
provider to obtain that information from the payer. 909

(2) Any product or network for which the participating 910
provider is to provide services; 911

(3) The term of the health care contract; 912

(4) A specific web site address that contains the identity 913
of the contracting entity or payer responsible for the 914
processing of the participating provider's compensation or 915
payment; 916

(5) Any internal mechanism provided by the contracting 917
entity to resolve disputes concerning the interpretation or 918
application of the terms and conditions of the contract. A 919
contracting entity may satisfy this requirement by providing a 920
clearly understandable, readily available mechanism, such as a 921

specific web site address or an appendix, that allows a 922
participating provider to determine the procedures for the 923
internal mechanism to resolve those disputes. 924

(6) A list of addenda, if any, to the contract. 925

(B) (1) Each contracting entity shall include a summary 926
disclosure form with a health care contract that includes all of 927
the information specified in division (A) of this section. The 928
information in the summary disclosure form shall refer to the 929
location in the health care contract, whether a page number, 930
section of the contract, appendix, or other identifiable 931
location, that specifies the provisions in the contract to which 932
the information in the form refers. 933

(2) The summary disclosure form shall include all of the 934
following statements: 935

(a) That the form is a guide to the health care contract 936
and that the terms and conditions of the health care contract 937
constitute the contract rights of the parties; 938

(b) That reading the form is not a substitute for reading 939
the entire health care contract; 940

(c) That by signing the health care contract, the 941
participating provider will be bound by the contract's terms and 942
conditions; 943

(d) That the terms and conditions of the health care 944
contract may be amended pursuant to section 3963.04 of the 945
Revised Code and the participating provider is encouraged to 946
carefully read any proposed amendments sent after execution of 947
the contract; 948

(e) That nothing in the summary disclosure form creates 949

any additional rights or causes of action in favor of either party. 950
951

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law. 952
953
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958

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form: 959
960
961

"SUMMARY DISCLOSURE FORM 962

- (1) Compensation terms 963
 - (a) Manner of payment 964
 - [] Fee for service 965
 - [] Capitation 966
 - [] Risk 967
 - [] Other See 968
 - (b) Fee schedule available at 969
 - (c) Fee calculation schedule available at 970
 - (d) Identity of internal processing edits available at 971
972
 - (e) Information in (c) and (d) is not required if information in (b) is provided. 973
974

(2) List of products or networks covered by this contract 975

[]	976
[]	977
[]	978
[]	979
[]	980
(3) Term of this contract	981
(4) Contracting entity or payer responsible for processing payment available at	982 983
(5) Internal mechanism for resolving disputes regarding contract terms available at	984 985
(6) Addenda to contract	986
Title Subject	987
(a)	988
(b)	989
(c)	990
(d)	991
(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer.	992 993 994 995
IMPORTANT INFORMATION - PLEASE READ CAREFULLY	996
The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) <u>3963.01(I)</u> of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract	997 998 999 1000

constitute the contract rights of the parties. 1001

Reading this Summary Disclosure Form is not a substitute 1002
for reading the entire Health Care Contract. When you sign the 1003
Health Care Contract, you will be bound by its terms and 1004
conditions. These terms and conditions may be amended over time 1005
pursuant to section 3963.04 of the Ohio Revised Code. You are 1006
encouraged to read any proposed amendments that are sent to you 1007
after execution of the Health Care Contract. 1008

Nothing in this Summary Disclosure Form creates any 1009
additional rights or causes of action in favor of either party." 1010

(C) When a contracting entity presents a proposed health 1011
care contract for consideration by a provider, the contracting 1012
entity shall provide in writing or make reasonably available the 1013
information required in division (A)(1) of this section. 1014

(D) The contracting entity shall identify any utilization 1015
management, quality improvement, or a similar program that the 1016
contracting entity uses to review, monitor, evaluate, or assess 1017
the services provided pursuant to a health care contract. The 1018
contracting entity shall disclose the policies, procedures, or 1019
guidelines of such a program applicable to a participating 1020
provider upon request by the participating provider within 1021
fourteen days after the date of the request. 1022

(E) Nothing in this section shall be construed as 1023
preventing or affecting the application of section 1753.07 of 1024
the Revised Code that would otherwise apply to a contract with a 1025
participating provider. 1026

(F) The requirements of division (C) of this section do 1027
not prohibit a contracting entity from requiring a reasonable 1028
confidentiality agreement between the provider and the 1029

contracting entity regarding the terms of the proposed health 1030
care contract. If either party violates the confidentiality 1031
agreement, a party to the confidentiality agreement may bring a 1032
civil action to enjoin the other party from continuing any act 1033
that is in violation of the confidentiality agreement, to 1034
recover damages, to terminate the contract, or to obtain any 1035
combination of relief. 1036

Section 2. That existing sections 1753.07, 1753.09, 1037
3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code are 1038
hereby repealed. 1039

Section 3. The following represent the General Assembly's 1040
intent and findings: 1041

(A) The provisions of this act seek to prevent dental 1042
insurers, dental benefit plans, and other contracting entities 1043
from establishing fee limitations on services that are not 1044
covered dental services for enrollees under a dental insurance 1045
plan. 1046

(B) Strategies by dental insurers, dental benefit plans, 1047
or other contracting entities to adopt or impose a deductible, 1048
copayment, coinsurance, or any other requirement in such a way 1049
as to provide de minimis reimbursement for services as a method 1050
to avoid the impact of this law is contrary to the spirit and 1051
intent of the General Assembly. 1052